Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amenditem#5, perFH, G8 that of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2005 10 nor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Si Montgomer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Also (In yrs. last birthday, COSS 6. Sex If Under 1 Year 9. Birthplace (State on Foreign Country) 578562 2236 **Funeral** Days Months 89 2 1 □ M 2 XF Yrs Wash Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State other then "natural", or iteme 23a or 28a-f ehow vent, the Medical Examiner must be notified at 1 Yes 2 No DC Washinato Director 10g. Citizen of What Country? 101-Zip Code 10e. Street and Number 20018 AVENE 4001 Dakot by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2XNo 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Blac 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Education Elementary/Secondary (0-12) College (1-4or 5+) eacher 5 t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental and Mental Be lia 5 recn ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 20783 Adelphia Health a Angela S 1 Dau. 1904 Glenn Laguna 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any Injury or ot
once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Kiverdale -14-05 ' 4 ☐ Donation 5 ☐ Other (Specify) ramhers John 21. Signature of Funeral Service Licensee 22. Name and Address of Facility NE Wash Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner THMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the attended for us 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 nknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 Yes 2 No this certificate 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After 1 Natural 2 Accident 5 Pending To the recent within 24 hours efter death.

To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D19609 raman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMA(V MD ROAD SUITE 202 GAITHERSBURG 10810 DARNES TOWN 31. Date filed (Month, Day, Year) State FEB 1 6 2005 Registrar

		For	State of Maryland		ent of Health and	•		gibie.	
		1 - State Registrar		Certific	ate of Death	F	leg. No	105	07002
Phys	sician	Decedent's Name (First, Middle, Last)	/ GIAITII ID			2. Date of Dea Month	Day	Year	3. Time of Death
/Me	edical	JOSEPH HENRY			The Town or Location of Dec	2	11	2005	12:32 P ^M
Exam	miner	4a. Facility Name (If not institution, give s Atlantic General		40. C	ity, Town, or Location of Dea Berlin	tn		cester	
Funer	ral		7. Age (In yrs. la		nder 1 Year If Under 24 Hrs				lace (State or Foreign try)
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A h the	Director	10e. Street and Number			Zip Code		l0g. Citizen	of What Coun	try?
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. (7.7.	Funeral	TT. Wighter Ottates	Was Decedent Ever in U.S Armed Forces?	3. Was De	ecedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. F	lace - America llack, White, e	
d 21215-0036 d 21215-0036 Hygiene. outper than "naturel", or frame on the Hygiene.	by Fu	1 Never Married Married 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Kore Year or Dates:	ea ¹□Ye	s 2X No Specify:		Spe	city: Whi	ite
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O. ne dear the a	Sic	1 Yes 2 No	4☐Pregnant at time of de 9☐Unknown	ath 5 Cother	(specify)		1		
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isio ttend death stor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	M form street for	1 Yes 2 No	28f. Location (S	treet and Nu	mber or Rural	Poute Number
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Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edica C	(Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examinati	vledge, death occur ion and/or investigat	red at the time, date and plac tion, in my opinion, death occ	e, and due to the curred at the time, d	ause(s) and ate and plac	manner as sta e, and due to	ated. the cause(s)
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Reg	istrar	LED T 9.50	DE MENTE ,	U proposition					

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	/Medic Examin		4a. Facility Name (If not institution				4b. City,	Town, or	Location of		Februar		County of Dea	
\$2.		ζ.	3101 Floral Pa	rk Road					ywine				ince Ge	eorge's
	. Funeral Director		5. Social Security Number 494-22-2912 Usual Residence of Decedent	6. Sex 1 □ M 2 X 1 F	7. Age (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Nov. 18	Year)	9. Bi	rthplace (State or Foreign country) SOUP1
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nor	Pages 1 ar nent of Hea ant: If item 3 ury or other		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Cen	netery, crei	natory or o	ther place	ry 2				ataway,	
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Division	al or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At homing, etc. (Specify)	e, farm, str	eet, factory	, office		28	8f. Location (St. City or Town			ural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	g Physicien: To the Examiner: On the b	best of my knowle asis of examination ner stated.	edge, death n and/or in	occurred a restigation,	at the time in my opi	e, date and inion, death	place, an	d due to the ca	ause(s) ate and	and manner as place, and due	s stated. e to the cause(s)
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	Registr		31. Date filed (Month, Day, Year)	. 5 2005	altern .	S.	good							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State amend item #8 PER FH C842 4/94/1/19419pf Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** A M AGNES ELTON SIMS 2005 3:40 February 13, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Glade Valley Nursing Home Walkersville Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 7 (Month, Day, Var)
March 15, 1919 Great Britain 5. Social Security Number 6. Sex **Funeral** 1 M 2 F 230-26-3538 85 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits itam 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event. If e.M. Alical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Virginia Newport News 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 52 Denbigh Blvd. "naturel', or items 23a U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ges 1 and 2 should be filed within 72 hours affer it of Health and Mental Hygiene. If item 27 is marked othar than "naturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher NN Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Elton Alice Lester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Sims 202 Captains Lane, Newport News, Virginia 23602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ital
any injury or oth 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Peninsula Mem. Park 2/18/05 4 ☐ Donation 5 ☐ Other (Specify) Newport News, Virginia 21. Signal of F ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Meinone /Medical Due to (or as consequence of): Acadent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 attending physicien Physician/Medical as the for use a 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 ☐ Yes 2 🗌 No 22 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after To the Hospital c within 24 hours aff To the Funaral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 29c. License number MEB 2005 e and address who completed cause of death (Item 23a) (Type, Print) PROBRICK ND 31. Date filed (Month gistrar's Signatur State Registrar

		1 - For State Registrar	State of M	Maryland / Dep Ce	partment of Health and ertificate of Death		ene2005 0700
Physici	an	Decedent's Name (First, Middle,	Last)			2. Date of Death Month	Day Year 3. Time of Death
/Medi		Jane	В.	St	rang	February	
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		Rockville Nurs	ing Home		Rockville		Montgomery
Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 ☐ F	Age (In yrs. last birthda) 87 Yrs.	Months Days Hours M	Hrs. 8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country)
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and		10a. State 10b. County		10c. City, Town or	Location		10d. Inside City Limit
Mary	ō	Maryland Montg	omerv	Silver	Spring		1 ☐ Yes 2☐N
15e	Director	10e. Street and Number			10f. Zip Code	100	g. Citizen of What Country?
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permit. Peges 1 end 2 Department of Health a Importent: if item 27 is any injury or other tre once.		Robert M. Rice	/ DPOA		5 Waterway Drive		
Pariminole, Permit. Peges 1 el Department of Hea mportent: if item any injury or othe		20a. Method of Disposition 1 December 2 □ Cremation	3 □Removal from Sta		ematory or other place)		c. Location - City or Town, State
Pariti Mark		'4 □Donation 5 □Other (Sp		Parklawn	Memorial Park 2	2/15/2005 Ro	ockville, Maryland
mit. spart sport y inj		21. Signature of Funeral Service V.	icensee		22. Name and Address of Facility	lines Rinald	li Funeral Home
J 89E 8 9		Trance +	Men	Du 1			ver Spring, MD 20904
certificate be executed Example Inding physicien and Inding by some as the burial-transit Inding by the burial-transit Inding By the burial-transit Inding By the burial-transit Inding By the	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o Septio	as a consequence of): CALCENIA as a consequence of):	ion		
cate be exc ohysicien a the burial.	dlcal		d. Dement	ia			
tifica ng ph as th	led		1				
the death y the atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		n 2 ☐ Fetal death 3 t at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
res that igned by be deta	by Pi	Part II. Other significant condition	ns contributing to death	h but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
requires sen sign rould be	d b					1 ☐ Yes	2 No 3 Probably 4 Inknow
w require been sij	Completed					24a. Was an	24b. Were autopsy findings availab
The law requires t sate has been signe page 2 should be o	L D					 autopsy performe 	prior to completion of cause of death?
bat d		CE Was seen referred to madisal					No 1 ☐ Yes 2 ☐ No
	o Be	25. Was case referred to medical examiner?	Hospital:		Other	Death (Check only one)	
a in in in in	 	1 Yes No 27. Manner of Death	1 □ Inpa		BIIL 3LI DOA 4 4 14dISIII	28d. Describe how	ce 6 ☐Other (Specify)
Afte Tune	Certification:	natural 5 ☐ Pending 2 ☐ Accident investigs 3 ☐ Suicide 6 ☐ Could no	ation ot be	Day Year) Injury Injury - At home, larm,	Wark? M 1 ☐ Yes 2 ☐ No		et and Number or Rural Route Number,
or A Olirection by	ertif	4 Homicide determin	building,	etc. (Specify)		City or Town,	State)
urs a			Dhamising To the be-	st of my knowledge, de	ath occurred at the time, date and pl	ace, and due to the cause	se(s) and manner as stated.
the Hospitel of in 24 hours a the Funerel Explored pletely filled in	edical	(Check only 2 Medicel E	xaminer: On the basis and manner	s of examination and/or stated.	investigation, in my opinion, death o		and place, and due to the cause(s)
To the Hospitel or Attentivities within 24 hours after deall To the Funerel Director: completely filled in by the		(Check only one) 2 Medicel E 29b. Signature and title of certifier	xaminer: On the basis and manner	stated.	investigation, in my opinion, death o		and place, and due to the cause(s) Date signed (Month, Day, Year)
To the Hospite within 24 hours To the Funerel completely filled	edical	(Check only 2 Medicel E	xaminer: On the basis and manner	s of examination and/or stated.	29c. License number	290	Date signed (Month, Day, Year)
To the Hospitel of within 24 hours a To the Funerel E	edical	(Check only one) 2 Medicel E 29b. Signature and title of certifier	examiner: On the basis and manner	USMU.	29c. License number D47330	290	
To the Hospite within 24 hours To the Funerel completely filled	edical	(Check only 2 Medicel E 29b. Signature and title of certifier 200. Name and address of person w	manner: On the basis and manner	of death (Item 23a) (Type	29c. License number D47330 a, Print)	29d	Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** M Shaughnessy 9:30 a 11, William John February 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arden Courts Montgomery

9. Birthplace (State or Foreign Country) Kensington
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 6. Sex **Funeral** 5. Social Security Number Hours Min. 1**⋈**M 2□F Months Davs Director 207-01-6526 Dec. 20, 1917 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or Items 23a or 28e-f show the Medical Exemple or must be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 322 University Boulevard, East 20901 USA Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, the Mudical Example in must 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No !f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 □ Divorced WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ۵ William J. Shaughnessy Genevieve Dunleavy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau 3714 Marlbrough Way College Park, Maryland 20740 <u>Marilyn Jarboe</u> Daughter 20b. Place of Disposition (Name of crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Gate of Heaven 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)Entombment Cemeters Feb. 15, 2005 Silver Spring, MO 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 D Ru 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Aspiration Pneumonia 5 days /Medical Due to (or as a consequence of): **Examiner** Chronic Debilitation 3 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Dementia 3-5 years that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🛛 No 1 TYes 2 1 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 X No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funerel Director; / 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier MANNE CON US D 02338 February 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard P. Delaney, M.D. 3929 Ferrara Drive Wheaton, Maryland 20906 32 degistrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 5 2005 Registrar

			For State Registrar	State of Ma	ıryland / Depa <i>Cei</i>	artment of h			ne .No.2005	07007
	Physici /Medic		Decedent's Name (First, Middle, Li DOROTHY	sst) SAGER				2. Date of Death Month FEBRUARY	Day Year 12, 2005	3. Time of Death 8:40 A M
	Examin		4a. Facility Name (If not institution, git MONTGOMERY GENERA			4b. City, Town, o	r Location of Death		4c. County of Death	
	Funeral Director			Sex 7. Age 1 □ M 2 🗓 F	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 02/06/191	9. Birti Co 6 MICH	nplace (State or Foreign untry) IGAN
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or Items 23s or 28e-f show any injury or other traumatic event, I'm Medical Exp. fractrium be rediffed at once.	ted by Funeral Director	10a. State 10b. County MARYLAND MONTGOM 10e. Street and Number 3700 INTERNATION 11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced 15. Decedent's 8	AL DRIVE #2 12. Was Decedent E Armed Forces? 1 □ Yes 2 N N If Yes, Give Year or Dates:	ver in U.S. 13. V	ING 10f. Zip Code 20906 Vas Decedent of H Yes, specify Cuba U Yes, 2X No	lispanic Origin? (Spe an, Mexican, Pueno Specify: ation	ecity Yes or No-Rican, etc.)	. Citizen of What Co . S . A . 14. Race - Amere Black, White Specify: W.	rican Indian, ,, etc. HITE
2121	d within 7 giene. rr than "r	Completed	(Specify only highest gi	College (1-4or 5-	life I	DO NOT use retired	during most of worki d)		UCATION	
yland	nd 2 should be filed th and Mental Hyg 27 is marked othe traumatic event,	To Be C	17. Father's Name (First, Middle, Las MAX	FINKLE			18. Mother's Name			
Baltimore, Maryland	ges 1 and 2 sho t of Health and If item 27 is m or other traum		19a. Informant's Name/Relationship ARLENE PERKINS/DA 20a. Method of Disposition 1 ∠Burial 2 □ Cremation 3 1	UGHTER	14 BA	YSWATER (CT., GAITH	HERSBURG,	ity or Town, State, Z MD 20878 c. Location - City or T	
Baltim	permit. Pag Departmen Important: any injury once.		1 d □ Donation 5 □ Other (Special Signature of Funeral Service Lices	fy)		NZANSKY-(SOLDBERG N	MEMORIAL	ELPHI, MAR CHAPELS, 1 LE, MD 208	INC.
8760,	/Medical by physician and burial-transit sthe burial-transit	cai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	a. CARCINOI: Due to (or as a Due to (or as a	D TUMOR consequence of):	er the mode of dyin	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 68	death certif e attending ed for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delive Month	rery Day Year
	sign d be	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the un	derlying cause give	en in Part I.		co use contribute to	the cause of death?
I Reco	: The law requate has been page 2 shoul	Completed		·				24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
Division of Vital Records,	Attending Physician: The It result. r death. sctor: After this certificate ha.	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2X No 27. Manner of Death 1X Natural 5 Pending investigation investigation.	Hospital: 1 X Inpatien 28a. Date of Injury (Month, Day		28c. Injun Work	26. Place of Death er: 4 □ Nursing Hon / at k? Yes 2 □ No		e 6 ⊡Other (Speci njury occurred	fy)
Divis		Certification:	3 Suicide 6 Could not to determined		ry - At home, farm, stre (Specify)	eet, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one)	nysician: To the best of niner: On the basis of a nd manner stat	examination and/or inv	occurred at the timestigation, in my or	ne, date and place, a pinion, death occurre	nd due to the caused at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
)		×	29b. Signature and title of certifier		mb	29c. License			Date signed (Month, BRUARY 12,	
	12		30. Name and address of person was			Print)				
ľ	Sta Registr		JOSEPH KAPLAN, M. 31. Date filed (Month, Day, Year) FEB 1 5 2		's Signature		OUNEI, MA	INTLAND Z	J032	

	ician dical niner	Amend Item flagstate WCHD/SH 2 1. Decedent's Name (First, Middle Reva Exana Slagstate) 4a. Facility Name (If not institution 200 Belview)	2/17/05 per e, Last) nipley n, give street and numbe Avenue	FH (4b. City, Town,	Death or Location of Death	Reg. I 2. Date of Death Month Feb	No. Day Veal 15 2005 4c. County of Dea	nn Co	
Funer Direct		5. Social Security Number 232-26-4210 232-26-9210 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ X = 7. A	Age (In yrs. last birth	nday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yea October	ar)	thplace (Si buntry) Vest	
Maryland a-f show	ctor	10a. State 10b. County	nington	10c. City, Town	or Location rstown		7,		10d. Insi	
th with the	ai Director	10e. Street and Number 200 Belview 2	Avenue		10f. Zip Code	742	50	Citizen of What Co		
21215-0036 3 within 72 hours after death with the Maryland siener than "naturel", or items 23s or 28s-f show the Maryleal Exemiter rust be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Tyes 2 2	No No	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Sp pan, Mexican, Puerto		14. Race - Ame Black, Whit Specify: W	erican India e, etc.	
21215-0036 ad within 72 hours aff giene. er than "naturel", or than Mudical Exerci-	Completed	(Specify only highe	t's Education st grade completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work ad)	ing 16b	. Kind of Business	Industry	
44 500 -	0	Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle,	College (1-4o		Shipping Cl	1		Toy Mfg		
E ed la p	To Be	Thomas McInt				Russell	e (First, Middle, Maid Krouse	Krouse		
Mary		19a. Informant's Name/Relations Jerry B. Shiple			Mailing Address (Stree				ryland 2170	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other traumatic.	+	20a. Method of Disposition Surial 2 Cremation 4 Donation 5 Other (S	3 □Removal from Stat	20b. Place of cemeters	Disposition (Name of r, crematory or other pla even Cemete	ice)	Date 20c.	Location - City or gerstown	Town, Sta	
Physicia /Medic	10	23. Signature of Funeral Service 23a. Part1. Enter the disease, or shock, or heart silure. List Immediate Cause (Final disease or condition resulting in death)	a.	line.	1331 East of enter the mode of dy next Deg	ern Blvd. ing, such as cardiac	glas A. Fi N. Hagers or respiratory arrest,	iery Fund stown Mar	vland Appro- Interva Onset	
cate be executed physician and the burial-transit	je je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a	is a consequence o	f):					
Box 6 death certifi e attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	zy		23d. Date of de Month	ivery Day	
S, Se that greed be de	þ	Part II. Other significant condition		but not resulting in		ven in Part I.		co use contribute to	the caus	
Rec The law ate has b page 2 sl	Completed	Aortíc Va Hypul	pidenie	-			24a. Was an autopsy performed	2 death?	itopsy find completion	
OT VITA Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:		0	han	h (Check only one)			
on of ling Phy After this	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir	28a. Date of Ir (Month, L		ime of 28c. Injury		ome 5 Residence 28d. Describe how in		cify)	
Division of Attending latter death. Director: After	ertification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of I	njury - At home, far etc. <i>(Specify)</i>	m, street, factory, office	-	28f. Location (Street City or Town, St	t and Number or Ritate)	ural Route	

To the Hospital within 24 hours a To the Funeral completely filled

05H-10 State Registrar

32. registrar's Signature

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHERY AVE 747

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0026579

29d. Date signed (Month, Day, Year)

HAGERSTOWN, MANYLAND

29a. Certifier

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Day 16, Month **Physician** Smith February 2005 9:35 P M Marv Jane /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany Cumberland Villa Nursing Center Cumberland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F Yrs. Director 214-07-2415 08/21/1917 Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ahow the Medical Examinant - ust by multipolat 1)∑Yes 2 No MD Allegany Cumberland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 229 Baltimore Avenue 21502 IISA "natural", or Itams 23a Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itan any injury or other traumatic evant. The Medical Experiment 2008. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank G. Stierstorfer Minerva Felker ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry W. Smith / son 1667 Artemas Road, Artemas, PA 17211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Christian Cem. 02/20/2005 Inglesmith, PA 4 □ Donation 5 □ Other (Specify)21. Signature of Ineral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on/each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronny Pnysician 104/13 /Medical Due to (or as a con wuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 24 No Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No safter death 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a tion the cause(s) and manner as stated. 2 ☐ Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical and manner stated. within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10033280 Feb 18,200) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n ss Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, MD 31. Date filed (Month, Day, Year) 32. Restrar's Signature State FEB 18 2005 ·Registrar

			1- State of Maryland / Department of Health and I 16b, 20b, 30 per FW/JWR-03/91/05ath 841	Mental Hy dhb	giene	2005	5 07010
1	Physic		1. Decedent's Name (First, Middle, Last) Hilda Kathryn Selby	2. Date of De			3. Time of Death 8:15 AM
	/Medi Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frostburg Village Frostburg		4c	. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 159-16-1030 1 M 2 TF 89 Yrs. 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da 4-18-1	rth ay, Year)	9. Bir	thplace (State or Foreign ountry) RISDALE PA
	the Maryland 28a-f show	Į.	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	with the Na or 28a-	Direct	MD ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code		10g. Cit	izen of What Co	21
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiane. Health and Menial Hygiane. tiem 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Medical Exertine roust by notified at	by Funeral Director	28 TAYLOR ST 11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ★ No If Yes, Specify Cuban, Mexican, Puerton Year or Dates: 11. Was Decedent of Hispanic Origin? (Single Free Specify Cuban, Mexican, Puerton Year or Dates) 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerton Year or Dates: 13. Was Decedent of Hispanic Origin? (Single Free Specify) 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Yes, specify Cuban, Mexican, Puerton Yes Company Comp	pecify Yes or No o Rican, etc.)	US -	14. Race - Ame Black, Whit Specify: WHI	e, etc.
21215-0036	filed within 72 hours Hygiene other then "naturel", ant, the Medical Exe	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Usual Occupation (Give kind of work done during most of work iffe. DO NOT use retired) HOUSEWIFE	king	_	nd of Business	
Maryland	2 should be filled withir and Mental Hygiene. Is marked other then eumatic event, the M	To Be	17. Father's Name (First, Middle, Last) ANDREW J. STEELE PEARL EV	ANS			
	0 0		1 Rurial 3 Compation 3 Demonstrate State cemetery, crematory or other place)	Date		r Town, State, 2	
Baltimore,	permit. Pag Department Importent: I eny injury o once.		SUNSET MEMORIAL GARDENS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WVU HUMAN GIFT REG MORGANTOWN WV 2650	SISTRY	KI	NGWOOD	WV
68760,	Coate be executed /Medical Examiner sthe burial-transit	al Examiner	23a. Part1. Enter the disease of complications acaused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	or respiratory an	rest,		Approximate Interval Between Onset and Death
P.O. Box 687	death certif e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Solo 9 Unknown Un		2	3d. Date of deli	very Day Year
	law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dement of Dislocates milletus		bacco u		the cause of death?
of Vital Records,	The ate ha	Completed		24a. Was a autop: perfor	sy	24b. Were aut prior to condeath? 1 \(\text{Yes}	opsy findings available ompletion of cause of
ž Vit	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? Yes 2 40			□Other (Speci	ifv)
Division	ending Peath. or: After the funera	Certification;	25a. Date of injury Shalter of injury 25b. Injury at 28b. Injury at	28d. Describe h	ow injury	occurred	**
Divi	To the Hospitel or Attending is within 24 hours after death. To the Funerel Director: After completely filled in by the funer		building, etc. (Specify)	City or Town	n, State)		al Route Number,
	the Hosp nin 24 hou the Fune npletely fi	Medical	29a. Certifier (Check only one) 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the c ed at the time, d	ause(s) a ate and p	and manner as solace, and due to	stated. o the cause(s)
i	Viti Con	<	29b. Signature and title of certifier D 2 1 2 4 4	2	9d. Date	signed (Month,	
_			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Ho Tan, M.D., Frostburg Village Nursing Home		/		
B	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 1 ZUUD 32. Registrar's Signature				

			For State Registrar	State of I	Maryland / Depa	artment of He			jiene eg. No. 20 (15 07011
			Hegistrar Decedent's Name (First, Middle, in the content of the content	ast)				2. Date of Dea	th	3. Time ol Death
	Physici		Canning H. Stock					Month Februar	Day Y	00:01 a ^M
	/Medio Examir		4a. Facility Name (If not institution, g	rive street and numb	er)	4b. City, Town, or L	ocation of Death		4c. County of	
			Chester River Ma			Chestert	OWN If Under 24 Hrs.	10.00 (5.0	Kent	But I (O)
ь	Funeral		5. Social Security Number 163-03-5057	. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day May 7,	Year) 1915 F	. Birthplace (State or Foreign Country) A
	Director		Usual Residence of Decedent					, , , , , , , , , , , , , , , , , , ,		
	ehow		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 X No
	Ba-1 e	Director	MD Kent		Worte		***		0.00	
	with th	Dire	10e. Street and Number 12784 Coopers	Lane		10f. Zip Code 21678			I0g. Citizen of Wha USA	at Country?
	ns 23	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of His	panic Origin? (S	pecify Yes or No-	14. Race -	American Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If itam 27 is marked other than "natural", or Hems 23e or 28e-f ehow or other traumatic event, the Medical Examinat must be natified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 (XYes 2) If Yes, Give Year or Date	es? □No	if Yes, specify Cuban 1 ☐ Yes 2 🔀 No	Specify:	o Rican, etc.)		White, etc. White
Maryland 21215-0036	72 hou	Completed	15. Decedent's		16a. Dece	dent's Usual Occupat kind of work done du	ion iring most of wor	rking	16b. Kind of Busin	ness/Industry
21	within lene.	mple	Elementary/Secondary (0-12)	College (1-4	or 5+) life.	DO NOT use retired)	ŭ		Em array C	
121	iled w Hygier ther ti		17. Father's Name (First, Middle, La	st)	Acce	untant	18. Mother's Nar	ne (First, Middle,	Energy S Maiden Sumame)	ouppiler
and	d be f	To Be	Canning Newton	,				Hussong		
ary	2 should be filed within n and Mental Hygiene. 'ie marked other than "raumatic evant, the Wes	F	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street ar			r, City or Town, Sta	ate, Zip Code)
Ž,	and 2 paith a n 27 ig ar trai		Marty Stock/Son		Part of the last o	Coopers :				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tra once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe			osition (Name of matory or other place, cometery		Date . 9,2005 (20c. Location - Cit Clarksbor	
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Li	Hellen	lei [Name and Address e11ows, Ho 30 Speer	elfenbe: Road, Ch	in & NEwn nestertov	nam Funer vn, MD 21	al Home, P.A. 620
8760,	American and white burial-transit	dical Examiner	23a. Part1. Enter the disease, or coshock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sales in the conditions of the cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence of): as a consequence of): as a consequence of):	horlote	Cone	r		Onset and Death
.O. Box 68	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 🗍 Fetal death 3 [nt at time of death 5 [Ectopic pregnancy Other (specify)			23d. Date of Month	,
۵	uires that i signed by Id be deta	by	Part II. Other significant condition	s contributing to dea	th but not resulting in the t	nderlying cause giver	n in Part I.	23e. Did to		ute to the cause of death?
Records,	e law has t	Completed						24a. Was a autop perfor	sy prio med? dea	re autopsy findings available rr to completion of cause of th?
Vital		Bec	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only or	ne)	
of V	Physician: this certific ral director,	10	1 ☐ Yes 2 No	Hospital: 1 □ Inp			4 Nursing F		ence 6 Other	(Specify)
o uo		lon:	27. Manner of Death 1 Natural 5 Pending		Injury 28b. Time of Injury	Work?	at ? es 2 ⊡No	28d. Describe h	ow injury occurred	
Division	or Attendi ifter death. Diractor: A in by the fu	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determin	t be 28e. Place of	f Injury - At home, farm, st g, etc. <i>(Specify)</i>		03 2 110	28f. Location (S City or Tow		or Rural Route Number,
_	To the Hoepital or Attending within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune	Medical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bas caminer: On the bas and manue	est of my knowledge, deat is of examination and/or in r stated.	h occurred at the time vestigation, in my opi	e, date and place nion, death occu	e, and due to the curred at the time, c	ause(s) and mann late and place, and	er as stated. If due to the cause(s)
	To the Vithin To the	Me	29b. Signature and litle of certifie	20 H		29c, License	number 96031		29d. Date signed (/	Month, Day, Year)
-			30. Name and address of person w	ho com ploted cause	of death (Item 23a) (Type	Print) RA			72×70W	r, mo
	St Regist	ate rar	31. Date liled (Month, Day, Year)	9 2005 32. Re	strar's Signature	fort				

			1 - For State Registrar	State of Maryland		rtmen tificat				F	Rag. No.	005	07012
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) JOHN MARVIN TURNE	CR, SR.		41 -				2. Date of Dea Month Februa	ry 12,		3. Time of Death 2:25 p
	Examir	er	4a. Facility Name (If not institution, give: 6201 54th Place		.1: 11 1		erda1	Location of _e if Under 2			Prin	nty of Death	
	Funeral Director		5. Social Security Number 6. Security Number 223-14-8760	7. Age (In yrs. Ia.	Yrs.	Months		Hours	Min.	8. Date of Birtl (Month, Day May 2,	v. Year)		lace (State or Foreign try) inia
iore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23s or 28s-1 show any injury or other traumatic event; it a Medical Executed the profiled at once.	To Be Completed by Funeral Director	10a. State 10b. County Maryland Prince Ge 10e. Street and Number 6201 54th Place 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educy Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) John Valter Turne 19a. Informant's Name/Relationship (Ty, Fay Turner French 20a. Method of Disposition 1 Burial 2 MCremation 3 IR	12. Was Decedent Ever in U.S. 13. Was Married 1 1 1 1 1 1 1 1 1						g (First, Middle, Route Numbe	Specific Spe	of What Counter ace - Americal ack, White, city: Whi Business/Incounter ace ame) m. State, Zip nd 207 n - City or To	an Indian, etc. te dustry n Code) 37 wn, State
Baltimore,	permit. Pag Department Important: any injury o			Metro	22 4	Name an	d Address alti	s of Facility more	Gas Ave.	2005 ch's Fi , Hyati	uneral tsville	Home,	
8760,	Physician /Medical Examiner the prival-transit	dicai Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):	Jascu	lar						Interval Between Onset and Death
.O. Box 68	requires that the death certifics neen signed by the attending ph hould be detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 🗌	Ectopic pro Other (sp						Date of deliver	ry Day Year
Division of Vital Records, P.	aw 1s b 2 s	Completed by Ph	Part II. Other significant conditions con	. •	ing in the un	derlying ca	ause give	n in Part I.		23e. Did to 1 Y 24a. Was a autops perfor	es 2 No	3 Proba	e cause of death? ably 4 Unknown by findings available apletion of cause of
Vital	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	ospital:			Other			1 ☐ Yes (Check only or	2 No	1 Yes	
ion of	Phys rthis ral dii	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 El	P/Outpatient 8b. Time of Injury		Bc. Injury Work	at	28	e 5 🔀 Resida 3d. Describe h)
Divis	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)						City or Town	n, State)		Route Number,
	he Hospita n 24 hours he Funeral pletely filled	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	edge, death n and/or inv	occurred a estigation,	at the time in my opi	e, date and nion, death	place, ar occurre	d due to the c d at the time, d	ause(s) and n late and place	nanner as sta e, and due to	ated. the cause(s)
0	To the within 2 To the complete	Σ	29b. Signature and title of certifier 30. Name and address of person who co	mplated cause of death (from 3	(3a) /Tuno 5		License			2	2/14	red (Month, E	Day, Year)
1	Sta Registr		Peter M. Schissle 31. Date filed (Month, Day, Year) FEB 1 6 2005		Greenv	ay C	ente	r Dri	ve, i	∜430 , G	reenbe	1t, MI	20770

			1 - For State Registrar		aryland / Depa		lealth and I	Mental Hyg	200	5 07013
			Negistrar Nededent's Name (First, Middle, Last	st)		tinouto or	Dealit	2. Date of Dea	eg. No. 🚗 🔾 🔾	3. Time of Death
	Physicia	an	Dale A. Thomas					Month	Day Yea	r
	/Medic		4a. Facility Name (If not institution, give	a street and number)		4h City Town o	r Location of Death		4c. County of De	9:37
	Examin	er	Washington Ad		enital		ma Park	1		
-			5, Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year	tf Under 24 Hrs.	8 Date of Birth	Montgo	
	Funeral Director			№ м 2□F	49 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Aug. 24,	Year) 3. (1955 Ja	irthptace (State or Foreign Country) maica
	and and		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Many f sho led s	ō	Maryland Montg	omorii.	C + 1	as Constitute				1 ☐ Yes 2 🛣 No
	the t	Director	Maryland Montg 10e. Street and Number	Omery	pilve	r Spring		T 1	0g. Citizen of What (Country?
	with	ā	100 Plymouth St	reet		2090	0.1	'		
	hours after death with the Maryland tural; or Items 23a or 28a-f show at Examiliser must be notified at	Funeral	11. Marital Status	12. Was Decedent 8	ver in IIS 13 1			Dogity Vos or No	USA 14. Race - An	
	ter d	占	1.XXever Married 2 ☐ Married	Armed Forces?	10.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerl	o Rican, etc.)	Black, Wh	
36	irs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	03/15/1990	1 ☐ Yes 2 No	Specify:		Specify: B	lack
ŏ	tura	ed	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	s/Industry
15	n 72	Completed	(Specify only highest gra		(Give	kind of work done of DO NOT use retired	during most of wor	king		
212	with iene	E	Elementary/Secondary (0-12)	College (1-4or 5 2		chanical	Engineer		Automotiv	e Renair
D	Hyg ent,	e C	17. Father's Name (First, Middle, Last)					ne (First, Middle, I		e Repuir
Maryland 21215-0036	id be ental ked ic ev	To Be	Eric G. Thomas				Hilar	y M. Osh	orne	
7	shound M mar mat	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maitir	ng Address (Street			City or Town, State,	Zin Code)
<u> </u>	nd 2 Ith all 27 Is 1 trau	1	Doronalis M. Masshir	. / 0 = - +						
á	Hea Hea tem		Beverly M. Martin 20a Method of Disposition	n/Sister	20h Place of Disno	sition (Name of		Date	ney, MD 2	
٥	ages nt of		1 Burial 2 □ Cremation 3 □		Gate of Hea	natory or other plac		uary 16,		
altimore,	rtan rtan rjury		* 4 □ Donation 5 □ Other (Specify							ing,Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Marical Exampline I. wat the notified at once.		21. Signature of Funeral Service Licentification	ever Os	F 5	rancis J. 00 Univer	Collins sity Blv	Funeral	Home Inc	ing, MD 2090]
y,	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each tin	the death. Do not entre.			1	-	Approximate Interval Between Onset and Death
	/Medical		resulting in death)		consequence of):				,	
	Examiner			_						
		Jer	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):					
	be executed ician and burial-transit	Examin	Cause (Disease or injury that initiated events	C						
o,	exection and and and and and and and and and an	EX	resulting in death) Last	Due to (or as a	consequence of):					
760,	0 % 0	cal		d						
89	g phy as th									
ROX	The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_			23d. Date of de	elivery
ň	d for	cia	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at		Ectopic pregnancy Other (specify)			Month	Day Year
o.	the cry the acheo	Jys	9 Unknown	9□ Unknown						
1	that led b	Y P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Records,	w requires that been signed be should be det	d by	Diabete	eS				1 □ Ye	s 2 🗆 No 3 🗆 F	robably 4 Onknown
õ	v req beer shou	Completed						24a. Was ar	045 11/	
ě	has has	m						autops:	y prior to death?	utopsy findings available completion of cause of
<u></u>										s 2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Otho		h (Check only one	9)	
0	hys his	2	1 Yes 2 No 27. Manner of Death	1 Linpatier	-		4 LI Nursing Ho		nce 6 Other (Spe	ecify)
Ž	ding I h. After funer	on	1 Saturat 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	28c. Injury Work	c?	28d. Describe ho	w injury occurred	
Sic	tending leath. tor: After the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No			
Division	or At fter c Sirec n by	Certification;	4 Homicide determined	28e. Place of Inju buitding, etc	ry - At home, farm, stre . (Specify)	et, factory, office		28f. Location (Str City or Town	eet and Number or F , State)	lural Route Number,
	urs ai			1						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune	Medical	29a. Certifier Check only one) Certifying Ph. 2 Medical Exam	ysician: To the best on niner: On the basis of and manner state	f my knowledge, death examination and/or inved.	occurred at the timestigation, in my or	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	o th	Me	29b. Signature and title of certifier	- 1	1	29c. License	number	29	d. Date signed (Mon	th, Day, Year)
	P S P O		Clames K. Z.	stitfact,	4. M.P.	527	326		February	
		-	20 Name and address of	y y	-th (ham 00-) (T					
			30. Name and address of person who				d Desi	#202 5	o alessá 1.3 -	MD 20050
	-01		James K. Light 31. Date filed (Month, Day, Year)	20 -Decistes	da Cianatura		u prive,	#202, R	ockville,	עויז ענסטט
	Stat Registra		FEB 1 5 20	05	, & April	the same				
		5.L	EED 13 /11	U. I TO BELLE	A ALT ATTION					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year ARL IMMONS E S 1056 1 05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHING TON 1405 P.I 11/1 HAGERS TOWN COUNTY | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Jan. 25, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country Months 1 MM 2 □ F 69 218-30-7734 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits PA Fort Loudon Franklin 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17224 1120 Path Valley Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 III No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Fuel Oil Delivery Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David H. Timmons Wretha Irvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13830 Dry Run Road, Clear Spring, MD Jeffery L. Timmons/son 20a. Method of Disposition Date Blairs Valley Church Feb. 9,2005 Clear Spring, MD of God Cemetery 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lininger-Fries Funeral Home Inc. 47 N. Park Ave., Mercersburg, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death of delivery Day Year

> autopsy performed' 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28 No

28d. Describe how injury occurred

MVA HEAD ON COUISION

28f. Location (Street and Number or Rural Route Number, City or Town, State)

WASH

29d. Date signed (Month. Day, Year)

1 ☐ Yes 2 ☐ No

(0)

Physician /Medical **Examiner**

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or Items 23e or 28e-1 show ury or other traumatic event, the Medical Evantinal must be notified at

Baltimore, Maryland 21215-0036

Examiner physicien and the burial-transit Physician/Medical Completed by been signe should be Be 0 After th funeral Certification; filled in by the

25. Was case referred to medical examiner?

29b. Signature and title of certifier

31. Date filed (Month, 1)

5 Pending

investigation

determined

6 Could not be

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Hospital:

28a. Date of Injury (Month, Day Year)

14 05

MD

32. Registrar's Signature

The law requires that the death certificate be executed

To the Hospital or Attending Physicien:

death

hours after within 24 hours a
To the Funeral I
completely filled

Division of Vital Records, P.O. Box 68760.

oriodit, or riodit tailoro. Elot	any one deduction desir and.		interval bottoell
Immediate Cause (Final disease or condition resulting in death)	aCHEST_TRAUM#		Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):		
that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delivery Month Day Year
Part II. Other significant conditio	ns contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?

1 | Inpatient 2 | ER/Outpatient 3 | DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

pleted cause of death (Item 23a) (Type, Print)

28h Time of

10

AM

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 🖾 No

10011266

State Registrar

5H-3

			For State	State of Ma	-	Departm Certific			Mental Hy	-	DOOF	07015
		14	Registrar 1. Decedent's Name (First, Middle, Last)			Oorane	410 07 1	Journ	2. Date of De		(a (b) (b)	3. Time of Death
	Physici /Medic	-	John A Ti	mney					Month	Day	2005	10:59AM
2	Examin		4a. Facility Name (If not institution, give s			4b.	City, Town, or	Location of Deat			County of Dea	ith
	· iga		23110 ROY 5. Social Security Number 6. Sex		(In yrs. last bir	th do.() If I	Barto	n If Under 24 Hrs	9 Date of Bi		Allega	
D	Funeral Director			M 2□F		Yrs. Mor		Hours Min.	(Month, Da	iy, Year) 11, 1918		rthplace (State or Foreign ountry) Maryland
	ס		Usual Residence of Decedent		10.00.7				Ividy	11, 1710		•
	Marylar 8-f show	ctor	Maryland 10b. County Alleg	gany	10c. City, Tow	n or Location		Barton				10d. Inside City Limits 1 ☐ Yes 2 🗷 No
	n with the	al Dìre	10e. Street and Number 23110 R	loyal Lane		10	. Zip Code	21521		10g. Citi	zen of What C	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23c or 28a-f show any injury or other traumatic event, If a Modical Examitation and other traumatic events are a modical event and other events are a modical event and other events and other events are a modical event and other events and other events are a modical event and other events and other events are a modical events and other events are a modical event and other events and other events are a modical events and other events and other events are a modical events and other events are a mod	by Funeral Director	1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give		If Yes,	ecedent of Hi specify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	D-	14. Race - Am Black, Whi	
Ş	tural'	ed b	3 Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a.	Decedent's	Usual Occupa	ation		16b. Ki	nd of Business	
215	thin 72 9. Bm "na	Completed	(Specify only highest grade			(Give kind o	f work done o T use retired	during most of wo) _	rking	100.10		•
2	ed wit ygiene yer the	Соп	8	0	<u></u>			Paper				ishing
Maryland 21215-0036	utd be fill Aental H rked ott tic even	To Be	17. Father's Name (<i>First, Middl</i> e, <i>Last)</i>	illiam Timney	/			18. Mother's Na	me (First, Middle De		Sumame) irgrieve	
Mar	nd 2 shoulth and N		19a. Informant's Name/Relationship (<i>Ty</i> _l Donna Phillips/I		19b	. Mailing Add		and Number or Re oyal Lane So				
altimore,	of Hear item		20a. Method of Disposition		20b. Place of cemeter	Disposition ry, crematory	(Name of	- \	Date February 16,		cation - City or	
Ĕ	Page ment of ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Mt. View			2005	N	Moscow Mi	ills, Maryland
Balt	permit. Departi Import any inj once.		21. Signature of Funeral Service License	98			e and Addres		Home 8 Eas	st Main	St., Lonac	oning, Md. 21539
	¥		23a. Part1 Enter the disease, or compli shock or heart failure. List only or	cations that caused t	he death. Do	not enter the	mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
}	Physician		Immediate duse (Final disease or condition resulting in death)	Chron	ic obs	struc	tive	pulmona	ry dis	ease	9	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):						yrs
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	cuted nd ransit	Examiner	Sequentially list continues, if any, leading to immediate cause, Enter Underlying Cause (Disease or injury that initiated events									
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8760	cate b	dical	d									
9 X	eath certific attending p I for use as	a)	IF FEMALE: 2	3c. If yes, outcome o	f pregnancy						23d. Date of de	livery
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown			ic pregnancy r (specify)			1	Month	Day Year
۵.	res that the digned by the be detached	/ Ph	Part II. Dther significant conditions con	tributing to death but	not resulting in	the underly	ng cause give	en in Part I.	23e. Did	obacco u	se contribute t	o the cause of death?
rds	quires n sign ald be	q pa							1 🗆	Yes 2[□No 3□P	robably Unknown
Records,	e faw require has been si ge 2 should I	Completed							24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
	ician: Th certificate rector, pag	e Co	25. Was case referred to medical					00.01	1 ☐ Yes	2 No		2 □ No
Vital	ysicia s cert directi	To B	examiner?	ospital: 1 🔲 Inpatien	t 2□ER/Ou	tpatient 3	DOA Othe		dth (Check only of Resi		3 □Other (Spe	acify)
on of	Attending Physician: The Isr death. ector: After this certificate ha ector: After this certificate haby the funeral director, page	tlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. 7	Time of njury M	28c. Injury Work		28d. Describe			
Division of	를 를 들	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	rm, street, fa	ctory, office		28f. Location (City or To			ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the form of the filled in the form of the filled in the	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	sician: To the best of ner: On the basis of and manner state	examination an	e, death occu d/or investiga	rred at the tim tion, in my of	ne, date and place pinion, death occu	and due to the urred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	Fo the within Fo the comple	Me	29b. Signature and title of pertifier				29c. License	number		29d. Dat	e signed (Mont	th, Day, Year)
,-	h		1 6 0.1	fr	~		Do91	57		Feb	12 20	005
	200		30. Name and address of person who co	mpleted cause of de	ath (Item 23a)	(Type, Print)						
			Paul Sno	32 Registrar	Dpty 's Signature	Med E	x 12	24 W 3r	d St Ci	ımbe	rland	MD 21502
	Sta Registr		FEB 1 6 2	005 32. Hadistrar		1900	-					

			1 _ State	State of Maryland / De		ment of H			/ / / / /	15	07016
			Registrar 1. Decedent's Name (First, Middle, Last)		erun	cate of L	Jean	2. Date of Dea	Reg. No	0	3. Time of Death
	Physici /Medi		Julian	na Borys Timko				Februar		Year .005	0635 A M
	Examir		4a. Facility Name (If not institution, give st	reet and number)	4b.	. City, Town, or	Location of De		4c. County of		
			1415 Singerly Roa			E1kton	W11-20711	-	Ceci		
П	Funeral Director		5. Social Security Number 6. Sex 1 1 1	7. Age (In yrs. last birthd	Mo	Under 1 Year onths Days	Hours Mi		, Year) 1915	9. Birthpl	ace (State or Foreign try)
			Usual Residence of Decedent					July J	, 1915	рет	aware
	show ed at	č	10a. State 10b. County	10c. City, Town o		ın				10	Od. Inside City Limits
	the N 28e-f	rect	Maryland Cecil 10e. Street and Number	E1kton		Of. Zip Code			log. Citizen of W	hat Caup	1 ☐ Yes 2 📉 No
	h with	i Di	1415 Singerly Roa	d	,	21921			United		.,
	ems 2	ner			13. Was I		spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race	- America	an Indian,
36	s afte	by Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2 [YNo If Yes, Give A Year or Dates:		_	Specify:	nto rican, etc.)	Specify:	, White, e	91C.
8	2 hour	ed b	3 XWidowed 4 ☐ Divorced 15. Decedent's Educa			Usual Occupa	tion		16b. Kind of Bus	Whi	
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7	led wii lygien her th	Con	10		Iomen	naker			In Her		Ноте
and	t be fill he otled	Be	17. Father's Name (First, Middle, Last) Alyk Borys					ame (First, Middle, I	Maiden Sumame)	
Ž	should nd Me mark mark	ဥ	19a. Informant's Name/Relationship (Type), Print) 19b. M	ailing Ad	dress (Street ar		rine Gera Rural Route Number	City or Town S	tate Zin	Code
S	alth ar 27 Is or treu	1	Judith M. Hicks/Da					Elkton, M			
ore,	of Herof fitem rothe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rer	20b. Place of Dis	sposition	(Name of			20c. Location - C		
Baltimore, Maryland 21215-0036	Pag tment tent: I		' 4 ☐ Donation 5 ☐ Other (Specify)	Memoria	1 Pa	irk	22	, 2005	Elkton,	Mar	yland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event. The Medical Examiner must be notified at anone.		21. Signature of Funeral Service Licensee	11.	22. Nan Hick	ne and Address S Home	for Fu	nerals,_P	.A.		
			23a. Part1. Enter the disease, or complica	itions that caused the death. Do not	103	W. Stoc	ekton S	treet Ell	kton Ma	ryla	nd 21921 Approximate
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	11	à		Deme			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	/// <	101000		DETTIEV	1110		341
	LAMITHE	<u></u>	Sequentially list conditions, b.	Deate (or as a consequence of).		-					
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ROX	death s atter d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fetal death		or (specify)			23d. Date Month		y Day Year
J.	at the de by the a	hys	9 □ Unknown	9□ Unknown							
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d)	ela has	ompleted	()S/EDAV11	VINS				24a. Was ar autopsy perform	n 24b. We y prid ned? dea	re autops or to comp ath?	sy findings available oletion of cause of
	icien: Th certificate rector, pag	o e	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2 ath (Check only one	No 1L	Yes 2	□No
	Physicien: this certific ral director.	To B	examiner? 1 Yes 2 No Hos	pital: 1 Inpatient 2 ER/Outpat	tient 3[DOA Other		Home 5 Reside		(Specify)	
Nivision of	ing P			28a. Date of Injury 28b. Time (Month, Day Year) Injury	у	28c. Injury a Work?	at	28d. Describe ho			
<u>s</u>	ttend death ctor: / the f	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Płace of Injury - At home, farm,	M		s 2 No	204 Lagation (Ct.			
2	alor A after 1 Dire d in by	Certification:	4 Homicide determined	building, etc. (Specify)	зпеец, та	ictory, office		28f. Location (Str City or Town,	State)	or Hurai i	Houte Number,
	To the Hospitel or Attending Physicien: within 24 hours alter death To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only 2 Medical Examiner	en: To the best of my knowledge, de	ath occu	rred at the time,	, date and plac	e, and due to the ca	use(s) and mann	er as stat	ed.
	the H hin 24 the F mplete	Medical		On the basis of examination and/or and manner stated.	investiga						
-	Co with		29b. Signature and title of certifier			29c. License r	number	29	d. Date signed (/	Month, Da	ay, Year)
1	0	+	30. Name and address of person who comp	eleted cause of death (Item 23a) /Tun	e. Print\	Day	7/3	Dan W	21	8 6	15
-	1		III W High St.	Suite 214	£1	Kton	ara A.	Parey M.	/	4	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Spe	w	/		1		
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				ype or Prin					•		_	
			1 - For State Registrar		, ,		tificate of l			Reg. No		
			Decedent's Name (First, Middle, Last)						2. Date of De	aath Da	2005	3. Time of Death
	Physicia /Medic		Norman James	Thoma	s				FEB.			5:15 P M
	Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, or	r Location of Death			. County of Death	
_			Salisbury Nursing a 5. Social Security Number 6. Sex	nd Rehab	Cent	er ast birthday)	If Under 1 Year	Salisbury If Under 24 Hrs.	8. Date of Bi		icomico	lace (State or Foreign
	Funeral Director			M 2DE	85	Yrs.	Months Days	Hours Min.	June 2	y Year	918 De.	laware
h			Usual Residence of Decedent									
	inylan ahow	L.	10a. State 10b. County			, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f a	Directo	Maryland Wicomi	CO	M	larde]				10- 0	Nin an of 14th at Court	
	with t		10e. Street and Number	Бес			10f. Zip Code 21837	7			itizen of What Cour	iti y r
	filed within 72 hours after death with the Maryland Hygiene. Hygiene there insturel; or Items 23a or 28a-f ehow off, the Macified Examiner must be notified at	Funeral	25945 Quinton R	2 Was Decedent F	Ever in U.S	S. 13. \		ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		14. Race - Americ	
0	or Iter		1 Never Married 2 Married	Armed Forces? 1 Yes 2 □ N	10	ł	f Yes, specify Cuba I□Yes 2⊠No		Rican, etc.)		Black, White,	etc.
3	rel', c	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates: [√	VW 2		TU Yes 212 No	Specify:			Specify: Bla	ack
ה	72 h "netu	Completed	15. Decedent's Educ (Specify only highest grade			(Give	lent's Usual Occup- kind of work done	during most of work	ing	16b. K	(ind of Business/Ind	dustry
7	within ane. then	mp	Elementary/Secondary (0-12)	College (1-4or 5	i+)		00 NOT use retired Dorer	1)		1	lone	
7	Hygie Hygie other ant, II	ပိ	17. Father's Name (First, Middle, Last)			Дах	JOICI	18. Mother's Nam	e (First, Middle			
	lid be lental ked c	To Be	Fredrick Thomas					Edna A	lice H	lopk	kins	
Mary	d 2 should be filed within h and Mental Hygiene. 7 Is marked other then treumatic event, the Mental treumatic even	-	19a. Informant's Name/Relationship (Typ				•				or Town, State, Zip	Code)
<u>.</u>	of Health of Health 27 I		Rhoda Barrett (S	ister)				Rd.Marde	· · · · · ·			
ב ס	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Marular Hygiens. Department of Health and Marular Hygiens in Interpretent if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Macalcal Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	amoval from State			sition (Name of natory or other place	1	2/16/		ocation - City or To	
Dallino	t. Partmen		'4 □Donation 5 □Other (Specify)		Spr	- 00	ill Mem.		7 4/05		oron,Md.	
0	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service License	2towns	T	S1	ewart 1 21 West	Sufferal Rd.Sali	Home sbury	, Md.	21801	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused	the death.							Approximate
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	/Medical		resulting in death)	Due to (or as	a consequ				,			
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000	rtificat ng phy as th	led i	IE EELAN E									
א ם	ith certendir	ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1□Live birth	2 Fetal	death 3 [Ectopic pregnancy	,			23d. Date of delive Month	Day Year
	the all	Physicia	1 Yes 2 No	4□ Pregnant at 9□ Unknown	time of de	ath 5	Other (specify)					,
Ľ	The law requires that the death certificate be site has been signed by the attending physicis page 2 should be detached for use as the bur	/ Ph	Part II. Other significant conditions con	tributing to death bu	ut not resul	Iting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco	use contribute to th	ne cause of death?
cords,	uires sign	d by							1 🗆	Yes 2	□ No 3 □ Prob	ably 4 Unknown
5	s beer	Completed							24a. Was		24b. Were auto	psy findings available
ב	The la	mo							auto perfo	psy ormed? 2 No		npletion of cause of 2□ No
אומ	lan: irtifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of Deat				
> 5	hysica his ca I direc	70	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatie		R/Outpatien		4 Nursing Ho			6 ☐Other (Specify	1)
	ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	Work	y at k? Yes 2 □ No	28d. Describe	how inju	ry occurred	
200	ttend death stor: / the f	ertification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	iny - At hor	ne farm str		res 2 INO	28f. Location (Street ar	nd Number or Rura	l Route Number.
2	after Dirac	ertii	4 ☐ Homicide determined	building, etc	. (Specify))	501, 140101 9, 011100		City or To	wn, State	9)	
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	licai C	29a. Certifier 1 Certifying Phys (Check only onle)		examinati							
	o the	Medi	29b. Signature and title of certifier	1.12	7		29c. License	e number	0	29d. Da	te signed (Month, I	Day, Year)
	P S F O		1000	MI			000	2554	7	2	1/15	-
4	11,00		30. Name and address of person who con	mpleted cause of de	eath (Item	23а) (Туре,	Print)			-	100	
	.40		WILLIAM ROBINS, M.				,SALISBUR	RY, MD.	21804			
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 4 21	32. Registra			land.					
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	Dia.	u)	1. Decedent's Name (First, Middle, L.	ast)					2. [Date of Dea		JUJ	3. Time of Death
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	Exami	ner	4a. Facility Name (If not institution, gi	_			4b. City, Town, o				4c. Coun	ty of Death	
-			St. Mary's Hospi				Leonard					. Mary	7'S
5	Funeral Director			Sex 7. Age 1 M 2 F		st birthday) Yrs.	If Under 1 Year Months Days	Hours	Min. (/	ate of Birth Month, Day	Year)		place (State or Foreign
			Usual Residence of Decedent		40			J	Jui	ne 18	,1964	Tenne	essee
	laryland show		10a. State 10b. County		10c. City,	Town or Loc	ation					1	0d. Inside City Limits
	Ba-1-s	cto	Maryland St.	Mary's			Hollywo	od					1 ☐ Yes 2 🖥 No
	or 2	Director	10e. Street and Number				10f. Zip Code		-	1	0g. Citizen of	What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show rulust be millified at	ra	24420 Hollywood					636_			Jnited	State	es
	ter de Itam	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces?			as Decedent of H Yes, specify Cuba	lispanic O an, Mexica	rigin? (Specify ` in, Puerto Ricar	Yes or No- n, etc.)	14. Ra Bla	ce - Americ	an Indian, etc.
336	urs af	þ	3 Widowed 4 Divorced	1 ☐ Yes 2 ■ N If Yes, Give Year or Dates:	0	1	☐ Yes 2個 No	Specify	:		Speci	ity: Whit	e
Š	be filed within 72 hours after tal Hygiene. d other then "netural; or Its event, the M. Cital Examin.	Completed	15. Decedent's E	ducation		16a. Decede	ent's Usual Occup	ation			16b. Kind of E	Rusiness/Inc	dustry.
215	thin 7 e. an "n	lple.	(Specify only highest gri	ade completed) College (1-4or 5-	F)	(Give k life. D	ent's Usual Occup ind of work done O NOT use retired	during mo: d)	st of working			243111033411K	Justry
2	ed wi ygien nar th t, the	S	12				Clerk					Sales	3
and	be fill Hall Hall Hall hall off	Be	17. Father's Name (First, Middle, Last	,				18. Moth	er's Name (Firs	it, Middle, M	Maiden Surna	me)	
ž	should and Men marka	2	David Warren						ıdy Mari				
Maryland 21215-0036	d 2 si th an t7 is r traur		19a. Informant's Name/Relationship (Gary Barnes / Ste				Address (Street						Code)
	Heal Heal tam 2		20a. Method of Disposition	ep-Father	20b. Pla	ce of Dispos	Box 178,		Hall,		and 20 20c. Location		Citat
on O	Pages ant of nt: If I		1 ■ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special		cen	netery, crem	atory or other plac	1					.,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Itam 27 is markad othar than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Madical Examinal must be multiled at once.		21. Single of Funeral Se vice Lice	••	Cnar	ries M	emorial Name and Addres	Gdn. ss of Facili	2-26-20	005 1	eonard	ltown,	Maryland
ä	permi Depar Impor any ir		Edward N. Brinsf:	ield, Jr.	M0005	52 22	Name and Addres	vwood	rbrinsi Poad	leld	Funera	T Hom	e, P.A. 20650-0279
			23a. Part1. Enter the disease, or com shock, or heart failure. List only			Do not enter	the mode of dyin	g, such as	cardiac or resp	oiratory arre	est,	1, 111	Approximate
	Physician		Immediate Cause (Final disease or condition	_a Pneumonia									Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a			DIONEHI						
	LAdiliniei %	_	Sequentially list conditions,	b									
	led nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	nce of):							
^	executed an and rial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a	conseque	nce of):							
68760,	bu bu			ď		•							
	tificate ig phys as the	edical		V									
Вох	eath cert attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2	f pregnanc		ctopic pregnancy				23d. Da	te of deliver	y
	ne death the atte hed for	sici	in the past 12 months?	4☐Pregnant at ti			Other (specify)				Mo	onth (Day Year
P.0	that the dead by the detached	Physician/M	9 Unknown										
Records,	w requires tha been signed I should be det	d by	Part II. Dther significant conditions of Myocardial Fibr		not resum	ng in the und	erlying cause give	en in Part I.	. 2				cause of death?
Ö	> 0 70	etec	yourdidi Tibi	ODID						1 L Yes	2 🗆 No	3 Proba	bly 4 Unknown
Re	e la has	Completed							24	4a. Was an autopsy perform		prior to com	sy findings available pletion of cause of
Vital	ician: Th certificate rector, pag	e Cc	25. Was case referred to medical							Yes 2	□No	death? 1 Yes 2	2□ No
>	9	To B	examiner? 1 ★ Yes 2 No	Hospital:	2V V= D	VOutpatient	3□ DOA Othe	_	of Death (Char				
0	ig Physie this neral dis		27. Manner of Death	28a. Date of Injury (Month, Day)	28	3b. Time of	28c. Injury Work		rsing Home 5		ice 6 ∐Oth v injury occurr		
io	Attending r death. actor: After oy the fune	atio	1 ⚠Natural 5 ☐ Pending 2 ☐ Accident investigation		rear)	Injury		? ′es 2.⊟1					
Division of	or Atter after de Diracto	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	/ · At home (Specify)	e, farm, stree	t, factory, office		28f. Lo	cation (Stre	et and Numb	er or Rural	Route Number,
	urs af urs af ral D			1									
	Hospital 24 hours a Funaral I	lical	29a. Certifier (Check only (Check only 2X Medicel Exert	ysician: To the best of niner: On the basis of e	xamınation	edge, death o	ccurred at the time	e, date and	d place, and du	e to the cau	ise(s) and ma	nner as sta	ted.
	To the Hospital or Attending Phy within 24 hours after death. To tha Funaral Diractor: After this completely filled in by the funeral or	Medical	one) 29b. Signature and title of certifier	and manner state	d.		29c. License						
	F3F8		11/1/1/	11.							d. Date signed ebruar		* * * * * * * * * * * * * * * * * * * *
			30. Name and address of person who	completed cause of dea	th (Itam or	3a) /Tim= 5	OC:	ME		L.	enr ngr.	y 44,	2007
			THEODORE Mikin	Process Grand Grand	ar (iteill 23	a, (Type, Pri	111 Pe	nn St	reet F	Raltim	ore M	lorrel -	nd 21201
	Sta	ie	31. Date filed (Month, Day, Year)	0005	s Signature	9 40 4	4			<u></u>	ore, M	атута	na 71701
	Registr	ar	FEB 2 5	2005	د مع	I A	Care de la						

			For State Registrar	State of Marylar		artment rtificate					Reg. No.	200)5 n	7010
	/sicia ledica	n	1. Decedent's Name (First, Middle, Last Frances Evely							2. Date of De Month Februar	Day	2005	ar	ne of Death" **
	amine		4a. Fecility Name (If not institution, give				Town, or	Location o	of Death			County of D		
			Chevy Chase Mano 5. Social Security Number 6. Se		last birthday)	If Under	1 Year	If Under		8. Date of Birt	h		Birthplace (St	ate or Foreign
Fund Direc			577-16-8121		87 Yrs.	Months	Days	Hours	Min.	(Month, Da Oct. 5,	y, Year) 191		Country)	on, D.C
rland	14	-	Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation							10d. Insid	de City Limits
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Itams 23s or 28s-1 show	dilled	Director	D.C. N/A	Was	shingto			- -						Yes 2 □ No
or 2	2		10e. Street and Number			10f. Zip					-	zen of What		
ath v	1	20	4707 Connecticut		#414		0008	annin Ori	nin2 /6no	noifu Van or No		ted S	tates merican India	n
er de	Ne.	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ZNo	.5.	was Deced If Yes, spec	fy Cubar	n, Mexican	n, Puerto	ecify Yes or No Rican, etc.)		Black, W		и,
036 urs aft	9	۵	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No X	Specify:				Specify:	Black	
Maryland 21215-0036 d 2 should be tiled within 72 hours af the and Mental Hygiene. 27 is marked other then "naturel", or	ins Medical Examinar in	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	tion u <i>ring m</i> osi	t of worki	ng	16b. Ki	nd of Busine	ss/Industry	
within ene.	Ne Me	d m	Elementary/Secondary (0·12)	College (1-4or 5+)		tsman/					Fed	leral	Govern	ment
filed a there	<u>ب</u>	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)	•	
should be marked o	C	0 8	Carroll Fleet					Urs	elin	e Davis				
aryla should and Men	LT I		19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	/ Route Numbe	er, City o	r Town, State	e, Zip Code)	
e, M 1 and 2 Health iem 27 l	er tra		Lawrence Thomas/					cut A	ve.	N.W., #				20008
of He	<u> </u>		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐F		Place of Dispo cemetery, crer	sition (Nam natory or ot	e of her place)		ate	20c. Lo	cation - City	or Town, Stat	te
Pages ment of lant: If it			* 4 ☐ Donation 5 ☐ Other (Specify)	Ch	esapeal						Belt	svill	e, MD	
Baltimore, Marylar permit. Pages 1 and 2 should b Department of Health and Menit Important: If tiem 27 is marked	any in	Į	21. Signature of Funeral Service Licens	oo lers.	22 N	AcGuir	e Fu	nera	I Se	rvice N.W., W	aah	D C	2001:	2
N.	16	+	23a, Part1, Enter the disease, or compl	ications that caused the deat				-				р.с.	Approx	
Physic /Medi	ical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. <u>Cardiac Ar</u> Due to (or as a conseq		n i a							Onset	and Death
Exami		ner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying	Due to or as a conseq	uence of):									
Box 68760, death certificate be executed e attending physician and	mg e	icai Examiner	Cause (Disease or injury	Due to (or as a conseq	uence of):									
BOX 6 death certific	S	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ldeath 3□	Ectopic pre					2	23d. Date of o Month	delivery Day	Year
Records, P.O. The law requires that the le has been signed by the	eq .	۵	Part II. Other significant conditions co Dementia	ntributing to death but not res	ulting in the u	nderlying ca	iuse give	n in Part I.					to the cause Probably 4	
W req	shou	Completed	Cancer Rectum							24a. Was		24b. Were	autopsy findi	ngs available
و و و	age 2	E O								autop perfor	med?	death	o completion ? es 25 No	of cause of
Vital F sician: The certificate	tor. p	0	25. Was case referred to medical					26. Place	of Death	(Check only o				
of Vita Physician: rthis certific		0 8	examiner? 1 ☐ Yes 2 ☐ Xo	Hospital: 1 Inpatient 2	ER/Outpatien	it 3□ D0/	A Othe	r: 4 📉 Nu	rsing Hor	me 5□Resid	lence 6	3 □Other (S	pecify)	
On of ding Phy After this	ıneral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work	at ?	2	28d. Describe h				
IVISION Attentiter death	in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	M eet, lactory,		'es 2 □ l		28f. Location (5 City or Tow	itreet and m, State)	d Number or)	Rural Route i	Number,
Hospita 4 hours Funeral	= 1.	edical C		sician: To the best of my kno ner: On the basis of examina and manner stated.										se(s)
To the within 2	comp	Me	29b. Signature and title of certifier	. 0		29c.	License	number	,		29d. Date	e signed (Mo	nth, Day, Yea	ar)
./)	g			D005	4566			Feb	ruary	11, 20	005
1>	and the state of t		30. Name and address of person who							•				
			Sunitha Bhogavill			Јорр	a Ro	ad,	Suit	te 230,	To	wson,	MD 21	286
Po	Stat	-	31. Date filed (Month, Day, Year)	32 Registrar's Signa	K de	we								

			1 - For State Registrar	State of	Maryland		artment of rtificate o		nd Mental H	ygiene	11115	07020
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Daisy Wr 4a. Facility Name (If not institution,	ight	ber)		4b. City, Towr	, or Location of	2. Date of Death	ry 1.		3. Time of Death 5: 46 AM
	Funeral Director	C.	Knollwoo 5. Social Security Number 237–36–1251		7. Age (In yrs. Ia	a <i>st birthday)</i> Yrs.	Mille If Under 1 Ye Months Day			irth Day, Year)	Anne Aru	hplace (State or Foreign untry)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince	George	,	Town or Lo	cation					10d. Inside City Limits
	ath with the Marylan 23e or 28e-f show	al Director	10e. Street and Number 2105 Waterleaf	Way			10f. Zip Code	20721			tizen of What Co	untry?
920	ter dez	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford ad 1 Yes 2 If Yes, Give Year or Da	es? 2.⊠No		Was Decedent of If Yes, specify C		in? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Amer Black, White Specify:	
1215-0	od within 72 hours a giane. er then "natural", o	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	S Education grade completed) College (1-	4or 5+)	(Give life.	dent's Usual Occ kind of work do DO NOT use ret	ne durina most (of working		Cind of Business/I	ndustry
Maryland 21215-0036	ba filed Ital Hygi od other avent, I	To Be Co	17. Father's Name (First, Middle, L Aaron Peele	ast)				Rhc	s Name (First, Middle da Peele	le, Maider	n Sumame)	
, Mar	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationsh Ernest Peele/S		act B	210)5 Water	leaf Wa	or Aural Aoute Num	llvi.	lle, MD	20721
Baltimore,	es Til		20a. Method of Disposition 1 □ Gurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	ecify)	late	dlawn	sition (Name of natory or other p Cemeter	y 2/	Date 17/05	Wil	ocation - City or I liamston	, NC
Balt	parmit. Pag Department Important: any injury o		21. Signature of Funeral Service	milla	ul	65 ح	Name and Add	ntown R	d. Camp S	prin		
	Physician /Medical Examiner	her	23a (Part1. Enter the disease or shock, or heart failure. List of shock, or heart failure. List of shock or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	ch line. EXEM or as a consequence as a	SRO ence of):	VASCU	LAR	DISEA	SE		Interval Between Onset and Death YEA-A-S
x 68760,	leath certificata be exacutad attending physician and I for use as the burial-transit	/Medical Examiner	resulting in death) Last	c	or as a conseque	•			11		23d. Date of deli	Verv
P.O. Box	The law requires that the death certifica tie has baen signed by the attending phy tage 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant. A in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown		th 2 ☐ Fetal nt at time of de wn		Ectopic pregna Other (specify)				Month	Day Year
	v requires that baan signed should be de	by	Part II. Other significant condition PELPHE				DISE		1	Yes 2	□No 3□Pro	the cause of death? bably 4 nknown
Vital Records,		e Completed	25. Was case referred to medical					26 Place	24a. Wa auti per 1 ☐ Yes	opsy formed? 2 No	prior to c	topsy findings available completion of cause of
ō	ays dii	ToB	examiner? 1 Yes 2 No 27. Manner of Death 1 Shatural 5 Pending 2 Accident investig	28a. Date of (Month)	patient 2 E Injury , Day Year)	ER/Outpatier 28b. Time of Injury	28c. Ir	Othon /	sing Home 5 Res	sidence		ilfy)
Division	in Pige	Certification;	3 Suicide 6 Could n 4 Homicide determin	ned 28e. Place of buildin	g, etc. (Specity,)	eet, factory, offic		City or To	own, State	9)	ral Route Number,
	the Hospital hin 24 hours the Funeral I mpletely filled	Medical	one)	y Physician: To the la examiner: On the base and manner	er stated.							
)	To with		1 Bric	wall.	en h	20	D	3/136		FER	BRUAR	4 14,2005
1	(3)	ta	30. Name and address of person v BL(AN C. W 31. Date filed (Month, Oay, Year)	who completed cause ALCACE	of death (Item	23a) (Type, 900)	Print) KI	LBLI	E RD,	BAZ	TIMORE	7 (4, 2005 T MD 21236
	Sta Registr		FEB 1 6 2	005	w &	And	W.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item #20b/2-16-05/wche/tiligate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Howard 11 Edward Winder /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salishuly
If Under 1 Year If Under 24 Peninsula Legional Medical NICOMICO 5. Social Security Number -7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 MM 2□F Days Hours Min. Yrs. Director 213-70-7607 50 Dec.30 1954 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or than "netural", or items 23a or 28e-1 show The Madical Examiner must be notified at Directo Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene important; if item 27 is marked other than "netural", or items 23a any injury or other traumatic event, the Madical Examiner miner pince. 29167 Double Tree Drive 21801 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel Winder Nola Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helena Winder (Wife) 29167 Double Tree DR.Salisbury, Md. 218011 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Quantico Cemetery 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Green Acres 2-17-05 Quantico, Md. 21. Signature of Funeral Service Licensee Stewart funeral Home Gladys B. 821 West Rd.Salisbury, Md.21801 Stewar 23a. Part1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ASCUD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/MedIcal IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the all 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After

completely filled in by the funeral

Be

Certification: To

Medical

25. Was case referred to medical

examiner? 1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 THomicide

1 Natural

within 24 hours a

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and vite of certifier 29c. License number H50497

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) 2/14/05

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

1 Tyes

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Day

3 ☐ Probably 4 Monknown

2 No

Year

Year

スリリフ

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 No

Birthplace (State or Foreign Country)

Maryland

Black

2005

30. Name and address of p mo completed cause of death (Item 23a) (Type, Print)

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day Year)

hRistophen mycles 100 E Carroll Street Salisbury mai 21801 5C

2 R/Outpatient 3 DOA

М

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28b Time of

31. Date filed (Month, Day, Year) FEB 1 6 2005

5 Pending investigation

6 Could not be determined

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

Physician /Medical Examiner

1 - For Stata Registrar

Funeral Director

28e-f show other traumatic event, the Medical Examiner must be notified at Items 23a ŏ "netural" 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other then "r item 27 ŏ ō Department of Importent: If any injury or

Maryland 21215-0036

Baltimore,

Physician **Physician** /Medical **Examiner**

be executed

68760

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Records,

Vital

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Division or Attending

burial-transi physician as the t 158 the funeral After death. after death

5. Social Security Number Months Hours Days 1X M 2□ F 212-10-2293 Usual Residence of Decedent 10c. City, Town or Location 10b County 10a State Director Wicomico Maryland Salisburv 10f, Zip Code 10e. Street and Number 306 East William Street 21804 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Army 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 International Shipping 17. Father's Name (First, Middle, Last) Be Henry William Watson Ethel Mae 19a. Informant's Name/Relationship (Type, Print) Kathryn Watson (wife) 20a. Nethod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 4 □ Donation 5 □ Other (Specify) Signature of Funer wid H. CFSP 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) YPOXIF Due to (or as a consequence of) NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 TAILURE Completed 24a. Was an Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ပ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 □ No 1 Tes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 006051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Decedent's Name (First Middle Last) Day Month Voar 1235 John Elton Watson February 11, 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Peninsula egional Nedical Center WILLOMICO Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) May 15, 1918 Maryland 10d. Inside City Limits 1X Yes 2 □ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify White 16b. Kind of Business/Industry Dresser Industries 18. Mother's Name (First, Middle, Maiden Sumame) Nock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 East William Street, Salisbury, Maryland 21304 20c. Location - City or Town, State Parsons Cemetery February 19,2005 Salisbury, Maryland 22. Name and Address of Facility Holloway Funeral Home Professioanl Association 501 Snow Hill Road, Salisbury, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 20 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 4. JANNANAR AYAPINA 614 13 EASTEKN SHIRE

State

Registrar

31. Date filed (Month, Day, Year)

FEB 1 6 2005

To the Hospital within 24 hours a To the Funeral C

32. Segistrar's Signature

1_ 9	For State Registrar	State of	Maryland / Depa Cea	artment of F			ene . 2.005	07022
1. De	cedent's Name (First, Middle, L	ast)				2. Date of Death	4 0 0	3. Time of Death
Physician /Medical A	RTHUR EDWARD W	ARNER				Month FEBRUARY	Day Year	I . M
/INCUICAL.	acility Name (If not institution, gi		er)	4b. City, Town, o	r Location of Dear		4c. County of De	
	. MARY'S HOSPI	ral		LEONARD'			ST. MAR	Y'S
, l'unerai		Sex 7. 1⊠M 2□F	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day,	rear) (rthplace (State or Foreign country)
Usual	7-30-7356 Residence of Decedent		78 Yrs.			MAY 18,	1926 WA	SHINGTON, DC
0			10c. City, Town or Lo	ocation			 -	10d. Inside City Limits
MD Stor	ST. MAR	Y'S	CHARLOTTE	HALL				1 ☐ Yes 2 📉 No
with the Mar t or 28a-f st to ro 28a-f st Director	Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
rai 123a 135	449 CHARLOTTE			20622			U. S. A.	
	arital Status ☑ Never Married 2 ☐ Married ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	es? □ No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2ሺ No	ispanic Origin? (S in, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036 bd within 72 hours af gliene. ar than "natural", or the Medical Exam Completed by F	15. Decedent's E	ducation	16a. Deced	dent's Usual Occup	ation	10	6b. Kind of Business	
21215-0 ed within 72 ho yejene. har than "natur 1, the Medical Completed	(Specify only highest gi	ade completed) College (1-4	life. I	kind of work done on DO NOT use retired	during most of wo f)	rking		
Com Com	12		CLER	K		FI	EDERAL BUI	REAU OF INVST
Maryland 12. Sepond be file 13. Sepond be file 14. Sepond be file 15. Sepond be file 16. Sepond be file 17. Sepond be file 18. Sepond be file 19. Sepond be fi	ather's Name (First, Middle, Las	t)				me (First, Middle, Ma	aiden Sumame)	
To To Its	ANK E. WARNER	T 011	1		MAUD MAI			
Man than than than than than than than th	Informant's Name/Relationship NDACE E. OBERT					ural Route Number, (
The and Soar W	Method of Disposition	L/NIEGE	20b. Place of Dispo	sition (Name of		NE HUGHESV	Oc. Location - City or	
Baltimore, semit. Pages 1 a semit. Pages	☐ Burial 2 X Cremation 3 [☐ Donation 5 ☐ Other (Special Content of the Content o		ite cemetery, cren	natory or other plac				
21. S	ignature of Funeral Service Lice		BRINSFIEL	D-ECHOLS . Name and Addres	CK.FEB.	L4,2005 CF	IARLOTTE I	HALL, MD NL.HME.,P.A.
Dall permit perm	foren 1 8	I John	> M00641 30	195 THREE	NOTCH I	RD CHARLOT	TE HALL.	MD 20622
23a.	Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause on each	sed the death. Do not ente	er the mode of dying	g, such as cardia	or respiratory arres	t.	Approximate Interval Between
Physician Imme	ediate Cause (Final		entic show	K				Onset and Death
/Medical result Examiner	ting in death)	Due to (or	as a consequence of):			1		
Sague	entially list conditions,	b	asvances a	2 remer	os dene	ntea.		
p is cause	, leading to immediate a. Enter Underlying a (Disease or injury	- Due to (01)	аз а солзециелсе оту.					
that in resulti	nitiated events ing in death) Last	c. Due to (or a	as a consequence of):					
ilicate be executed graying as the burial-transit testing as the burial-transit endical Examiner		d						
	MALE:							
death c death c death c se attended for us sician/	MALE: Was decedent pregnant in the past 12 months? I Yes 2 No		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
be detail.	Other significant conditions	contributing to death	but not resulting in the un	iderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
v requires v requires been sign should be		····				1 🗌 Yes	2 Ø No 3 □ P	robably 4 Unknown
The law requires the case has been signed page 2 should be completed by						24a. Was an	24b. Were at	utopsy findings available
The I The Com						autopsy performe 1 ☐ Yes 2 ☐	d?/ death?	completion of cause of
T VItal III ystcian: The ystcian: The ystcian: The ystcian: The Second Sec	as case referred to medical aminer?				26. Place of Dea	th (Check only one)		
Physical direction To]Yes 2 ⊉No	Hospital: 1 Inpa			4 Nursing H	ome 5 Residenc		cify)
Division of Vital Ital or Attanding Physician: rs after death. ral Director; After this certification; To Be C Certification; To Be C	anner of Death Natural 5 Pending		njury 28b. Time of Day Year) Injury	28c. Injury Work	? _	28d. Describe how	injury occurred	
ttang death death death ctor; the fireat	☐ Accident investigatio ☐ Suicide 6 ☐ Could not b	0 200 01000 061	niunt . At home form stre		′es 2 □ No	29f Location /Ctm	4 No	
DIV after a after a after bring Jin by	Homicide determined	building,	Injury - At home, farm, stre etc. <i>(Specify)</i>	et, tactory, office		City or Town, S	et and Number or Ri State)	ural Houte Number,
	Certifier 1 Certifying Pi	nysician: To the be	st of my knowledge, death	occurred at the time	e, date and place	, and due to the caus	se(s) and manner as	stated.
thin 24 hosp the Hosp thin 24 hosp that Fune ampletely fill the Second S	(Check only 2 Medical Examone)	niner: On the basis and manner	of examination and/or inv	estigation, in my op	inion, death occu	red at the time, date	and place, and due	to the cause(s)
29b. S	ignature and title of certifier	1. /		29c. License		29d.	Date signed (Mont	h, Day, Year)
	Mehr	Villa	60573M	Do 06	473		02/13/0	2)
	me and address of person who	completed cause of	f death (Item 23a) (Type, F	Print)				
MP 341 MEH								
	RDAD AKHLAGHT Ate filed (Month, Day, Year)		YS HOSPITAL. strar's Signature	LEONARDTO	OWN MD	20650		

DHMH 17 Rev 1/2001

ARTHUR E WARNER

Gerald Francis Washington 4s. Feelin Name (Information Southern Maryland Hospital 5. Social Security Number 6. Sex Y. Months 6. Sex Y. Months 6. Curry Year I Plus Ger 22 Hrs. S. Date of British National Plus Number (Number of Number of Nu		5.	State Registrar Decedent's Name (First, Middle, La	t estate of Marylan					2. Date of De	ath	V Vear	3. Firme of De
Southern Maryland Hospital Social Region Yumbook Social Region To Apply Yumbook To Apply To Apply Yumbook To Apply To Apply To Apply Yumbook To Apply To									Februa	ary]	12, 200	5 14:30
S. Special Searchy Number 5. Special Searchy Number 6. Special Searchy Nu	xamine	er	and the second second second			,		ation of Dea	th			
Street and Number 100. County 100. Cou					last birthdav)			Jnder 24 Hrs		th		
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Second Part	E.	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces2	.S. 13.\	Was Deced	lent of Hispar	nic Origin? (Specify Yes or No)-		
18. Mother's Name (First, Middles, Mairisen Surmame) 18. Mothe	artinos.			1 ☐ Yes 2 ☐ No If Yes, Give					, , , , , ,			
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198. Informant's Name/Fallaconchip (Type, Prof) 198. Mailing Address (Street and Number or Place) 199. Informant's Name/Fallaconchip (Type, Prof) 199. Informant's Name/Fallaconchip (Type,	T T	Se C	17. Father's Name (First, Middle, Last,)						, Maiden	Sumame)	
198. Informar's Name/Relationship (Type, Print) 199. Marion E. Arrington / Sister 3420 Rickey Ave. #104 Temple Hills, MD 207 209. Method of Deposition 1. Signatury of Formar's Same Zero Coss) 200. Place of Disposition (Name of Date 200. Location City or Town, State Zero Coss) 201. Place of Disposition (Name of Date 200. Location City or Town, State Zero Coss) 202. Name and Address of Racilly Marshall's Funeral Rome of Commerce of Comm		ToE	John Washington					Bessie	Willis			
A Donation Sci Others (Speechy) Earnover Marshall's Funeral Rome Name and Address of Facility Name and Address of Faci				•	1							
A Contain Scholmer (Specify) Harmony Memorial Park 2-19-05 Landover, MD	thert				100000000000000000000000000000000000000		_	/e. #1				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflienced as shock, or heart flature. List only one cause on each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflienced as shock, or heart flature. List only one cause on each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflienced as inflienced as shock, or heart flature. List only one cause on each line. 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflienced as inflienced as the cause of t			1X Burial 2 Cremation 3	3rtemoval nom State				1 0 1				
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FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) Month Day	dical and principle princi	icai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseq	uanca of).	1-11	J pes	Jen.	1/0/			inkno
The state of the s	e as th	Med	IF FEMALE:									
The completion of death The completion o	ched for us	ysician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3							
autopsy performed?	p eq	þ		/7	ulting in the ur	nderlying ca	ause given in	Part I.				
autopsy performed?	shoul	etec	printfer						-			
28b. Time of Injury Work? 1 Passionce 6 Other (Specify) 28c. Injury at Work? 1 Pessionce 6 Other (Specify) 28c. Injury a	page 2	Comp							auto	osy orr ao d?	prior to death?	completion of caus
27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Cartifier (City or Town, State) 28b. Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	recto	0	examiner?	Hospital:	-		Other					
1	E P	\vdash		28a. Date of Injury			A 4	☐ Nursing I				ecify)
29a. Certifier (Check only one) 29a. Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	fune	tior	1 ☑ Natural 5 ☐ Pending	(Month, Day Year)	Injury			2 🗆 No			,	
29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	d in by the	ertifica	3 ☐ Suicide 6 ☐ Could not b	286. Place of injury - At no	ome, farm, stre	eet, factory	, office					ural Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	etely fille		(Check only 2 Medical Exar	niner: On the basis of examina	owledge, death	occurred a	at the time, do	ate and plac n, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as d place, and due	s stated. e to the cause(s)
50454 Feburum 1	omple	Me	29b. Signature and title of certifier			29c	. License nur	nber		29d. Dat	te signed (Moni	th, Day, Year)
			DO MA	+		5	041	-4	1	-01	hunn	. 18.
30. Name and addr_ss_person_no completed cause of death (Item 23a) (Type, Print)			1 1 1 19		00.10		()	,	1/		3 00 10	79129

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** 10, SARAH DOROTHY WASHINGTON FEB 1:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY Casey House 9. Birthplace (State or Foreign Country) 0 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 84 Director 215-20-3696 Yrs. Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Madical Erganinet must be nuffitled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14508 Homecrest Rd, #215 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 5 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) during most of working College (1-4or 5+) Elementary/Secondary (0-12) Cafeteria Manager Montg. Co. Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas A. Washington Lucy Bacon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ophelia J. Thomas (Sister) 5223 5th Street, NW, Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Mem Pk 2/19/05 Rockville, MD Devation 5 Other (Specify) ignate of Funeral Service Live ee 22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N. Washington St., Rockville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Widespread Metastatic Adenocarcinoma of /Medical Due to (or as a consequence of): Examiner the Ovary Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner sician and burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, sign be 3☐No 3☐Probably 4☐Unknown 1 🗌 Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗌 Yes **2€** No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 ☐ No Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) HospiceCertification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the 29b. Signatur, and time of ceoling 29c. License number 29d. Date signed (Mpnth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 Charles Harrison, M.D. 6001 Muncaster Mill Rd., Rockville, 31. Date filed (Month, Day, Year) Registrar

			1 - For State Registrar	State of Marylar	-	artment of F			giene Reg. No. () (05 07026
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of De.	Day	3. Time of Death
Н	/Medic	al	William	M.	V	Vellman,	Sr . r Location of Dea	Februar	y 5, 20	005 10:30 A.M
Н	Examin	er	4a. Facility Name (If not institution, give 10609 Peachtree L				amsport	UI	1	ington
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days			h	Birthplace (State or Foreign Country)
	Director		225-26-8202	M 2□F 80	Yrs.	Wonting Days	Tiours Iviii	Sept. 1		Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary F sho	tor	MD Washingt	on Wi	11iams	port				1 XYes 2 No
	or 28e	lrec	10e. Street and Number			10f. Zip Code	_		10g. Citizen of V	Vhat Country?
	ath wi	rail	10609 Peachtree I		- 1	21795			U.S.A	
	72 hours after death with the Maryland Insturel; or Items 23s or 28e-f show Ucal Examiliar must be molflied at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 □ No 194		Was Decedent of H If Yes, specify Cuba	lispanic Origin? () an, Mexican, Puei	specify Yes or No- rto Rican, etc.)		e - American Indian, ck, White, etc.
920	ol', or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 194		1 ☐ Yes 2 💢 No	Specify:		Specify	White
21215-0036	72 ho netur	Completed	15. Decedent's Ed (Specify onfy highest gra		(Give	dent's Usual Occup	during most of wo	orking	16b. Kind of Bu	usiness/Industry
121	within ane. then '	mpi	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		DO NOT use retired	•		City Go	vernment
d 2	filed Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last)					me (First, Middle,		
ılan	Menta Menta rrked	To B	John W. Wellman				Ola De	enny		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23a or 28e-f show other treumatic event, Ire Mardical Examination, and by mailified at	3	19a. Informant's Name/Relationship (7	•	1	ng Address (Street				
e, N	1 and Health em 27 ther t		Mary J. Wellman/Wi	20b. F	Place of Dispo	sition (Name of		, William Date		MD 21795 City or Town, State
Baltimore,	permit. Pages of the Department of the Importent: If ite any injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		matory or other place g Cremat	I	2005	Smithsb	
altir	mit. F partme porten / injur		21. Signature of Funeral Service Licen							al Chapel
Ö —	permi Depa Impo any ii		> S. Mark Sing	Y	16	01 Penns	y1vania	Ave., Ha	gerstown	n, MD 21742
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or coffi shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	(10 CC	er the mode of dyir	- 00			Approximate Interval Between Onset and Death G Weeles
		iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	bDue to (or as a conseq	uence of):					
8760,	cate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	c	uence of):					
9	ertifica ing ph e as th	Medi	IF FEMALE:							
P.O. Box	that the death certific ted by the attending p detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnation in Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	/		23d. Dat Mor	e of delivery nth Day Year
	requires that the leen signed by th hould be detache	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contr	ribute to the cause of death?
ord.	w requires that s been signed k s should be det	ted t						1 🗆 Y	res 2□No	3 Probably 4 ☑ Unknown
Division of Vital Records,	The law ate has b page 2 si	Completed							rmed?_ d	Vere autopsy findings available prior to completion of cause of death? ☐ Yes 2☐ No
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		eath (Check only o		
on of	ling Physicien: After this certific uneral director.	ion: To	1 ☐ Yes 2 ☐ Ño 27. Manner of Death 1 ☐ Naturel 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	y at	Home 5 Residence 1	dence 6 Other	
Jivisio	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, str y)		103 2 0,10	28f. Location (S City or Tow	Street and Numbern, State)	er or Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ledical C		ysician: To the best of my kno niner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my o	pinion, death occ	urred at the time,	date and place, a	and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	I (Month, Day, Year)
			muchand 4	1 Mulou	Mo	P.	4166	>	2.	7.05
11	1		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	1 /	1. 12		Month, Day, Year) 7.05
	1-/+/ Sta	te	31. Date filed (Month, Day Year) y	005 32. Régistrar's Signa	atur <u>o</u>	July Car	" " Liny	102 102	Jer/N	un INI).
	Registr		150012	LUUJ A COLON	10. 19	De year				

		•	For State Registrar		State of I	Marylan		artmen rtificat				ental H	Hygie Reg.	Ca C	05	07027
	Physic	an		e (First, Middle, Las Oliver	st)		Wir	th				2. Date of Month		Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	e street and numb	er)		4b. City,	Town, or	Location		Febru	ary		ty of Death	3:40_A
	LAGIIII	161	Bever1v	Healthcar	e of Fre	derick	τ	Fr	ederi	ick				Fre	ederi	ck
	Funeral		5. Social Security N 077-10-14	lumber 6. S		Age (In yrs. I		If Under Months	1 Year Days	If Under Hours		8. Date of (Month,	Birth Day, Ye			place (State or Foreign
Н	Director		Usual Residence o		A										1101	1011
	show		10a. State	10b. County		10c. City	, Town or Lo	cation								10d. Inside City Limits
	a-f st	ctor	Maryland	Frederic	k		Frede	erick	<u>.</u>							1 Yes 2 □ No
	with the	Directo	10e. Street and Nu 30 Nort	mber h Place				10f. Zip	Code 2170)1			10g.	Citizen of	What Cou USA	ntry?
	eath ne 23	eral	11. Marital Status	111100	12. Was Decede	ent Ever in U.	S. 13.	Was Deced	dent of His	spanic Or	igin? (Spe	cify Yes or	No-	14. Ra	ice - Ameri	can Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural; or Iteme 23a or 28e-f show other traumatic event, If a Medical Examinat must be notified at	by Funeral		ied 2 Married 4 □ Divorced	Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	X ^{No}		f Yes, sped 1 □ Yes		Specify:		Rican, etc.))	Speci	ack, White, ify: W	hite
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21215-0036	ithin 7 ne. nen "r	Completed	Elementary/Seco		College (1-4	or 5+)	life.	inisi	se retired)	i i i i i i i i i i i i i i i i i i i	, or working	.9		Do1-	iaiau	a/Churah
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aryl	should ind Men marke umatic	F		ame/Relationship (.I LII	19b. Mailir	ng Address	(Street a	27, 30		Route Nu	mber, Ci		n, State, Zij	
	other train		Eunice R	ockwe11/S	tep Daug		11 Ja			et, F			_			
Baltimore,	ges 1 of He If item or oth		20a. Method of Dis	position Cremation 3	Removal from Sta	ate C	lace of Dispo emetery, crei	natory`or o	ther place	9)	D	ate ,			- City or T	
Ë	Pag ment tant: jury o		` 4 Donation	5 Other (Specify	y)	Hur	ley Ce					nowr	H	urley	,New	York
Ball	permit, Pages Department of the Important: If ite any injury or of once.		21. Signatore of Fi	uneral Servide Licer				2. Name an			· 51				1 Hor	ne, PA
7	36		23a. P v 1. Rater	n e disease, or com In failure. List only	plications that cau	sed the death										Approximate Interval Between
	Physician		Immediate Cause disease or condition resulting in death)	(Final	a. FAI	LURE	= 7	OTH	HA	NE						Onset and Death
	/Medical Examiner		rooding in south			as a consequ	uence of):	ATH	ero	Sel	mos	2.5	Car	Lowm	ry	
		ner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	onditions, mmediate	D	as a consequ									-	
	icate be executed physician and s the burial-transit	Examine	Cause (Disease or that initiated event resulting in death)	S	c										_	
8760,	oe execian a		resulting in death)	Last	Due to (or	as a consequ	uence of):									
187		dlcal		•	d											
Вох 6	death certifica attending plant for use as t	√Me	IF FEMALE: 23b. Was deceden	nt pregnant	23c. If yes, outco									23d. D	ate of deliv	ery
	ne death the attern	Physician/Me	in the past 12 1 Tyes 2	! months? □ No		n 2 Fetal It at time of de		Ectopic pr Other (sp					-	М	lonth	Day Year
P.0	that the de ed by the detached	hys	9 🗌 Unknowr									20- 0	Cal Anhan			he source of death?
Records,	sign sign	by	Part II. Other signi	ficant conditions of	ontributing to deat	th but not rest	alting in the u	nderlying c	ause give	n in Part i	i.					he cause of death? bably 4 ②Onknown
900	ne law require has been ge 2 should	Completed										24a. V	utopsy	1	. Were auto	opsy findings available impletion of cause of
E.		Com										p 1□ Ye	erformed		death? 1 ☐ Yes	2 1 No
Vital	Phyelclan: Th this certificate al director, pag	Be	25. Was case reference examiner?		Unenital:				Otho			(Check or				
of	di S	P.	1 Yes 2 27. Manner of Dea			atient 2	ER/Outpatier 28b. Time of					ne 5 🗆 R 8d. Descri			ther (Specia	(y)
no	Jing After fune	tlon	1 Natural 2 Accident	5 Pending investigation	28a. Date of I (Month,	Day Year)	Injury	M	8c. Injury Work 1 □ Y	? ′es 2. 1 2	/	.00. 003011	50 11011	injury occu		
Division	Attanding r death. sector: After by the fune	Certification:	3 🗌 Suicide	6 Could not b	e 28e. Place of	Injury - At ho	me, farm, str	eet, factory	, office		2				ber or Rura	al Route Number,
Ö	s efter	Cert	4 Homicide		building	, etc. (Specify	′)					City of	Town, S	(ate)		
	To the Hospital or Attanowithin 24 hours efter death To tha Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	ysician: To the basi niner: On the basi and manner	s of examinal										
	To th within To th compl	Me	29b. Signature	title of certifier				1	. License				29d.	Date sign	ed (Month,	Day, Year)
			15	WY				Ţ	00	47	95		6	2 -	14-	2005
	7			ress of person who					_			m 011	707			
				te A. Kaz				enue,	Fre	deri	ck, M	D 217	/UI			
	Sta Regist	ate rar	31. Date filed (Mor	TEB 1 6	2005	istrar's Signa	No A	Social Contraction	7							

			1 - State Amend Item		,G841,O	3/02/8	ertilica	te of L	Death		-		05	070	128
	Physici	an	1. Decedent's Name (First, Middle, La		7						2. Date of Dear Month	Dav	Year	3. Time	
	/Medic	cal	Patrick 4a. Facility Name (If not institution, gir		alen		4b Cib	. Town or	Location of		Februar	-	2005 y of Death	9:0	00 A N
	Examin	ier	13500 Jamieson		91)		4D. OR	_	ntown			_	lontgo	mery	
F	uneral	4.1 	Social Security Number 6.	Sex 7.	Age (In yrs.	last birthda	y) If Und Months	er 1 Year Days	If Under 2 Hours		8. Date of Birth			lace (State	or Foreig
	irector		220-76-3430	1 ∑ M 2□F	50	Yrs	Worters	Days	Tiodis	741111.	(Month, Day, Aug • 24	,1954	Mar	y1and	
and	* 1		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or	Location						1	Od. Inside (City Limit
Mary	fsho	to	Maryland Montgo	omery				Germa	ntown	L				† X Ye	s 2 No
h the	r 28e	irec	10e. Street and Number				10f. Z	ip Code			1	0g. Citizen of	What Cour	itry?	
ith wit	23g c	ai D	13500 Jamieson I	Place					20874			Unite			
rs after dee	Important: If it is marked other than "neture!; or items 23s or 28e-f show any injury or other treumatic event, the Medical Eranding must be notified at once.	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	es? Xi No	.S. 1	3. Was Dec If Yes, sp 1 \(\sum \) Yes		spanic Origin, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)		ce - Americ ick, White, fy: W		
2 hour	eture cel E	led t	15. Decedent's E	ducation			cedent's Us					16b. Kind of 8	Business/Inc	dustry	
thin 7	Medi	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4)	or 5+)	life	ive kind of w a. DO NOT	rork done d use retired,	luring most (of working	g				
nd 2 should be filed within 72 hours aft	t a	Соп	N/A	N/A			Tra	inee	40.44.4		450	Vocat			
be fil	ed off	Be	17. Father's Name (First, Middle, Las	Whale	~					ian	(First, Middle, I	Maiden Suma	•	ailab	10)
hould	mark	입	Raymond 19a. Informant's Name/Relationship		11	19b. Ma	ailing Addre	s (Street a			Route Number	City or Town	 		TE)
nd 2 s	27 Is r treu		Jay Balint / Pro		ager	306	60 Mit	che11	ville	Rd.	#214;	Bowie,	MD	20716	ı
as 1 a	item		20a. Method of Disposition	7D		lace of Dis	position (Narematory or	ame of other place	э)	Da	ite	20c. Location	- City or To	wn, State	
Page	ent: If ury o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special	fy)		esape	eake (remat	ory	2/24	/05	Be1	tsvil	1e, M	D
permit. Pages 1 a	Import any inj		21. Signature of Fungal Service UC		M0038	32	Rapp	Funer	s of Facility al an	d Cr	emation er Spri	Servi	ces 20	910	
	sician		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that cau one cause on eac		testin	al Obst	de of dying	g, such as c					Approxima Interval Be Onset and	btween Death
	ledical iminer		resulting in death) Sequentially list conditions,	b. ————		ukocyt	olysis	of Unk	nown E	tiolog	y		2	-3 mon	ths_
pet	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq		Respira	drownz A	rmet				_	rediate	_
cate be executed	physician and s the burial-transit	dicai Exal	that initiated events resulting in death) Last	Due to (or	as a conseq				LICSL				HI.	Ванао	
death certifi	ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ∏ Feta tat time of d	l death	3 □Ectopic 5 □ Other (s						ate of delive	-	Year
The law requires that the	signed by the a d be detached f	b	Part II. Other significant conditions Severe Consti		h but not res	ulting in the	underlying	cause give	n in Part I.		23e. Did tob	acco use con		e cause of	
redni	been si should b	eted		Jacion							-				
	certificate has rector, page 2 s	Completed	Anemia								24a. Was ar autops perform 1 Yes 2	red?	prior to cor death? 1 \(\text{Yes} \)	osy findings npletion of a	cause of
Physicien: T	recto	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:	ationt 2	ER/Outpat	ient 3 🗆 🗆	Othe			<i>Check only on</i> e 5 XX Reside		or (Specifi	()	
iding Phy	: After this funeral di	tion: To	27. Manner of Death 1 X Natural 2 ☐ Accident 5 ☐ Pending investigated	28a. Date of I (Month,		28b. Time Injur	of	28c. Injury Work		28	d. Describe ho			/	
To the Hospitel or Attending Phy within 24 hours after death.	in b	Certification:	3 Suicide 6 Could not l 4 Homicide determined	280. Place of	Injury - At ho etc. (Specif	ome, farm,	street, facto	ry, office		28	Bf. Location (Str City or Town		ber or Rura	Route Nun	nber,
ie Hospi	To the Funerel I	Medical		hysician: To the be miner: On the basi and manner	s of examina										s)
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To			30. Name and address of person who			/	e, Print)						uary		
To			30. Name and address of person who Nancy D. River 31. Date filed (Month, Day, Year)	a-King M.		0_B	5x 955				D 21037	1001	uary		

			1 - For State Registrar	State of Maryla			t of H	ealth ar	nd Mental		ne 2 n	05	0702	(
Н	Physic	ian	Decedent's Name (First, Middle, Last)					2. Date Monti	n [Yeer	3. Time of Death	
}	/Medi Examii	cal	Tobitha Eliza 4a. Facility Name (If not institution, give		ner	4h City 1	Town or	Location of D		ary 12	, 2005 tc. County o	f Death	3:35 pm	Λ
1	Exami	ier	Manokin Manor Nurs					s Anne			Somers			
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under Months		If Under 24	Hrs. 8 Date	of Birth			ce (State or Foreig	ın
	Director		461-36-4687 Usual Residence of Decedent	77	Yrs.				April	21, 19	927	Loui		_
	within 72 hours after death with the Maryland ane. then "natural", or Itams 23s or 28s-1 show the Medical Evaminer must be notified at		10a. State 10b. County	10c. C.	ity, Town or Lo	ocation						100	d. Inside City Limits	ŝ
	8a-f s	Director	Maryland Somerset	Pr	rincess								1 XYes 2 □ No)
	with the a or 2	Dire	10e. Street and Number			10f. Zip				10g. (Citizen of Wh		y?	
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9	or Ita	/Fur	1 Never Married 2 Married	Armed Forces? 1		If Yes, speci 1 ☐ Yes 2	-	Mexican, F Specify:	Puerto Rican, etc	.)		White, et	c.	
21215-0036	hours ural',	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:							Specify:		ite	
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pu	2 should be filed withir and Mental Hygiene. is merked other than surnetic avant, the Ms	Be	17. Father's Name (First, Middle, Last)	_					Name (First, Mi		,			
Maryland	should ind Men in marke umatic	2	Edward Hade 19a. Informant's Name/Relationship (Ty	Brow	10h Mailie	on Address	(Step at a	Iren		lizab			lbourn	
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ore,	s 1 and of Health itam 27		20a. Method of Disposition	20b. I	Place of Dispo				Date	_	Location - C			-
Ë	Pages ment of I ant: If its ury or o		1 Burial 2 □ Cremation 3 □ P '4 □ Donation 5 □ Other (Specify)	temoval irom State				1	y Februar	y 15,	2005 Ma	ndela	Springs, M	D
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens	uly (FIP					Home Pad, Sal				ociation 21804	
8760,	Physician /Medical Examiner physician and physician and physician and physician sit in the physician and physician	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or a) (or a	uence of):	ha							nset and Death	
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregni 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c 9 □ Unknown	ıl déath 3 ⊑	Ectopic pre					23d. Date of Month	,	ay Year	
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	To the Hospitel or within 24 hours after To the Funeral Discompletely filled in	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knower: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at restigation, in	t the time n my opir	, date and pi nion, death o	ace, and due to occurred at the ti	the cause(: ne, date ar	s) and manne id place, and	er as state I due to the	d. e cause(s)	
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	Va.		Nathan				D 4	7014		ļ	2/14	105		
	300 m		30. Name and address of person who co	EZ ANI	1415 S	Print) - カルバ	SIUN	STVE	ec :	4215	BURY	-MD	21804	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 4 20	32. Agistrar's Signa	ture	rante								

3:35pm

Solute

Tobitha Wagner

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2005 10, Yeremin 9:53 Ivanovich February Nikolay /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1X7 M 2 □ F Director 1947 Russia Dec. 15, 220-67-8552 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28e-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Germantown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ or Items 23a 20876 21117 Hickory Forest Way Russia Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene.

Is marked other then "natural", or Itel 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Computer Programmer Computers 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melania Yeremin Makushkin Ivan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an item 27 ls 21117 Hickory Forest Way, Germantown, MD. 20876 Natalia Gnammakou/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite eny injury or ot 1 ₺ Burial 2 Cremation 3 Removal from State Ø ^ 4 □ Donation 5 □ Other (Specify) 2/12/2005 Germantown, Maryland All Souls Cemetery 22. Name and Address of Facility DeVol Funeral Home ture of Funeral Service Licens once 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic **Physician** 3 days /Medical Due to (or as a consequence of) Examiner Lenal if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Obstruction burial-transit certificate be executed Bowel resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Dav 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 1 No Physicien: 25. Was case referred to medical 26. Place of Death (Check only one examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death B Hospitel or Attending Pl 24 hours after death. B Funeral Director: After the Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier D61817 Februar 10,2005 Gla 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahyah Gharacholou, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month 32. Signature 4 MINE Registrar

			Pleas	e Type or Prin	t in Bla	ick Ind	delible	e Ink.	Ensu	ıre Al	l Copies	Are	Legit	ole.		
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	/Medic Examin		4a. Facility Name (If not institution,	give street and number)			4b. City,	Town, or	Location	of Death			c. County			*
			Suburban Hospit	al				ethe					Mont	gome	ry	
	Funeral		,	.Sex 7.Age	(In yrs. last 54	birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D. Sept	rth 22 ay, Year	1950	(:0111	olace (State ntry) lippi:	_
	Director		556-91-2323 Usual Residence of Decedent							!	bept.	23,	1334	1111	TTDDT	1165
	anylan show	<u>_</u>	10a. State 10b. County		10c. City, T									1	0d. Inside (City Limits s 2∑No
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00	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23e or 28e-f show many injury po-other traumatic event, the Madical Examinant to Indifficular and once.	by Funerai	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	II Yes, Give		i .			ispanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	0-		c, White,		
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Mary	nd 2 shoulalth and Mistra and Mis	1	19a. Informant's Name/Relationship Elizabeth Ycu/ V								l Route Numb					
oanumore,	Pages 1 and nent of Her int: If item		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			e of Dispos etery, crem awn Me	natory or o	ther place		ebru 200	ary 12 5	•	ocation - 0	•	own, State	and
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	Physician /Medical Examiner		23a. Part 1. Enter the disease, or of shock, or heart failure: List or Immediate Cause (Final disease or condition resulting in death)		eroscl	erosi		le of dying	g, such as	cardiac o	r respiratory a	rrest,			Approxima Interval Be Onset and 1 Hot	tween Death
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	ding P h, After funera	tion:	27. Manner of Death 1 Deatural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day	Year) 281	b. Time of Injury	М	8c. Injury Work	rat <br Yes 2. □		8d. Describe	how inju	ry occurre	d		
DIVISION	I or Attanding Physician: The after death. Director: After this certificate his in by the funeral director, page	Certification:	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determine	be Ose Place of lain	ry - At home, . (Specify)	, farm, stre					8f. Location (City or To			r or Rura	l Route Nun	nber,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai C	29a. Certifier (Check only one)	Physician: To the best of aminer: On the basis of and manner stat	examination	dge, death and/or inv	occurred estigation,	at the tim	ie, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s date an) and man d place, ar	ner as st nd due to	ated. the cause(s)
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			William B. Swann,					Rocks	ville,	MD 20	0814					
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			For State Registrar		ryland / Depa	artment of Health and Martificate of Death	Mental Hygie	-	07032
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yeer	3. Time of Death
	Physici		JANET M. ZARTMAN				02	10 2005	4:15 P M
	/Medic Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, or Location of Death	1	4c. County of Dea	th
		Ĭ.	8010 PINTAIL DRIVE			PARSONSBURG		WICOMI	
	Funeral Director		203-10-0093	M 2/7 F	(In yrs. last birthday) 80 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 10 02-16-19	'ear) 9. Bin Cc 24 PEN	thplace (State or Foreign ountry) NSYLVANJA
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ncation			10d. Inside City Limits
	anyla ahov	'n							1 X Yes 2 No
	the Marylar 28a-f show	ect	PA YORK		SPRING G	10f. Zip Code	100	g. Citizen of What Co	puntry?
	with a or	급		DEET		17362		USA	,
	18 23	era	188 W. HANOVER STI	2. Was Decedent E	ver in U.S. 13.	Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puerti	pecify Yes or No-	14. Race - Ame	
21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic event, the Medical Examinal must be modified at	by Funeral Director	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, GiveX Year or Dates:	0	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes X☐ No Specify:	o Rican, etc.)	Black, White	te, etc. HITE
Õ	2 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occupation	king 16	6b. Kind of Business	/Industry
215	within 7 ene. than 'n	ple	Elementary/Secondary (0-12)	College (1-4or 5-	+) life.	kind of work done during most of wor DO NOT use retired)	9		
	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	Son	12	2		HOMEMAKER		OWN HOM	E
pu	d oth	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, Ma	liden Sumame)	
yla	should be ind Mental marked o	2	JEREMIAH S. GENTZI			MARY R.			
Maryland	d 2 sho th and 7 lam traum		19a. Informant's Name/Relationship (Ty) BETSY L. WISMANS -			ng Address <i>(Street and N</i> umber or Ru PINTAIL DRIVE, PA		-	
Ġ,	permit. Pages 1 and 2 Department of Health a Important: If item 27 li any injury or other tra	U 8	20a. Method of Disposition		20b. Place of Dispo	osition (Name of		Oc. Location - City or	
Baltimore,	ages int of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☑ Donation 5 ☐ Other (Specify)	emoval from State	1	matory or other place) NT CEMETERY 02-14	-2005 YO	ORK, PENNS	VI WANT A
Ē	artme ortan injury		21. Signature of Funeral Service License	90 -					
Ba	Depa Impo Impo any ii		X Page X	8200.		05 EAS'I MAIN STRE		ERAL HOME	•
Series de la constante de la c	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Meta	the death. Do not en	ter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and De
68760,	cate be executed obysician and the burial-transit	dical Examiner	Secuentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):				
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<u>a</u>	S8 US 80	d by Pl	Part II. Other significant conditions con	ntributing to death bu	at not resulting in the u	underlying cause given in Part I.	23e. Did toba	~	o the cause of death?
Vital Records,	e law has b	complete					24a. Was an autopsy performed 1 Yes	prior to	utopsy findings available completion of cause of
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			26. Place of Dea	ath Check only The)	DAMODETER:
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<u>Ö</u>	Attending in death. ector: Alter by the funer	atic	2 Accident investigation			M 1 Yes 2 No			
Division	el or Att s after de al Directe ed in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	rry - At home, farm, st c. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospitel or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical			examination and/or in	in occurred at the time, date and place overstigation, in my opinion, death occurred.			
	within To the To the Comp	Ž	29b Signature and title of certifier	11/1/	7	29c. License number	29	d. Date signed (Mont	th, Day, Year)
	B		WH C	10/	M	Ud6278		d-11-0	21801
	Sa		30. Name and address of person who co	W, M	eath (Item 23a) (Type P. O . ar's Signature	Box 1733	Salish	, mD	21801
	Sta	ate	31. Date filed (Month, Day, Year) FEB I 4 2	005 32. Hearstra	ess orginature	South)		l'	

Amend item 10e per fh g844 6-21-05 vt
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 19b per fh g842 Certificate of Death

Reg. No.

Amend item 19b per fh g842

Reg. No. State Registrar Amend item 19b per fh g842 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death. Day **Physician** ADAMS February 12:25 4a. Facility Name (If not institution, give street and number) 2005 01ES 25 /Medical 4b. City, Town, or Location of Death County of Death Examiner PRAFFORd ort Washing Ton Place If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months WUS H 1 □ M 2 1 F Days Hours Min. 7.26.267 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside Çity Limits 10b. County 10a. State item 27 is marked other than "naturel", or itema 23s or 28e-1 show other traumetic event, the Madical Examinal must be notified at ffor Marlboro 1 es 2 No Completed by Funeral Director ٦ 13026 Boykin Place 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number CONE WAY 420 MITEC 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Black Specify: Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) zief NVISION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental out: if item 27 is marked o IRTHUY SONES TO ပ 196 MACA Baykins Place Upper Marilbons 19a. Informant's Name/Relationship (Type, Print) rafford Blackmon/daughter Bar bara J.D. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖬 Cremation 3 ☐ Removal from State 50 permit. Page Department of Importent: if any injury or once. Riverdale Genatory Riverdale, MD-* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 30 H St. NE. Wash., D.C. Z0002 B.K. HENRY toweral Home M01178 23 P.fh1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Hoterioscherotic Cardiovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ō Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 212 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) eces Other: 户 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 10.we funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitei 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVA do o Sylva Per, 31. Date filed (Month, Day, Year) 1505 3001

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

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2005

				State of Ma			c. Ensure All Health and M	•	-	e.	
			1 - For State Registrar		*	ertificate of			g. No.	07034	
	Physici /Medio		1. Decedent's Name (First, Middle, L RONNIE D	ast) AVER	2Y			2. Date of Death Month		3. Time of Death	
	Examir	ner	4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death							Death	
	Funeral Director		213-90-3363		TAC e (In yrs. last birthda 33 Yrs.	Months Days	if Under 24 Hrs.	8. Date of Birth (Month, Day, 7-26-7	Year)	Birthplace (State or Foreign Country)	
imore, Maryland 2	land ow		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	a-f sh	ctor	MD Baltimo			ore				X□Yes 2□No	
	vith the	Funeral Director	10e. Street and Number			10f. Zip Code				t Country?	
	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Introduce them 21 is marked other then "natural" or items 23a or 28a-f show sny injury or other traumatic svent, the Medical Exercities must be notified at once.	erai	4028 W. Coldsp.	ring Lane		21215		oitu Von er No	USA_	American Indian,	
		þ	1 Never Married 2 Married 1 Yes 2 No II Yes 3 Widowed 4 Divorced Year or Dates:			3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 → No Specify:			Black, \	Black, White, etc. Specify.Black	
		Completed	15. Decedent's E (Specify only highest g		16a. De	cedent's Usual Occu	pation during most of working d)	ng 1	6b. Kind of Busin	ess/Industry	
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	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship		19b. Ma	ailing Address (Stree	t and Number or Rura	l Route Number,	City or Town, Sta	te, Zip Code)	
	rages 1 and 2 nent of Health int: If item 27 I iry or other tra		Daisy Johnson (sister) 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart 3 3 Removal from State Sacred Heart 3 3 Dundalk, MD								
	permit. Pag Department Important: I sny injury o		21. Signature of Funeral Septice Licensee 22. Name and Address of Facility Wesley Chavis Jr. FH								
8	20 5 5 9		Wiskly Charty 2007 Eastern Ave. Balto. MD 21231								
A	Physician /Medical Examiner		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSIVE HEART DISEASE Due to (or as a consequence of):								
Division of Vital Records, P.O. Box 68760,	cate be executed by sician and the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	that the death certificate I ed by the attending physi detached for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			у		23d. Date of Month	delivery Day Year	
	res that igned b be deta	by Pł							cco use contribu	e to the cause of death?	
	w require been sig should b		END STAGE RENAL DISE			1567456	5AS€ 1□Yes			2 No 3 ☐ Probably 4 ☐ Unknown	
		Completed						24a. Was an autopsy performe	prior	e autopsy findings available to completion of cause of h? Yes 2 No	
		o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	26. Place of Death (Check only one) Hospital: Other: 4 Thursing Home 5 Theories of Figure 1997 Annual Control of the Control							
	Jing After fune	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No							
	tal or Att	Certification:	3 🗍 Suicide 6 🗎 Could not be 4 🔲 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, Sta						and Number or Rural Route Number, ate)	
	To the Hospital or Attencenthin 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
١	To the I within 2 To the I complet	Σ							I. Date signed (M	* * * * * * * * * * * * * * * * * * * *	
,			This Sha low D0035706 02, 25, 2005								
		l R	30. Name and address of person who ELIAS EHAND	completed cause of de	eath (Item 23a) (Typ	e Print)				0 21239	
	Sta		31. Date filed (Month, Day, Year)	JZ. Heristia	r's Signature	MI DO	OSPITAL L	JAL7/40	RE, 17.	0 4/237	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 28, 2005 **Physician** Constantine Christ Alexion 8:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Quail Run Assisted Living Perry Hall Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Sept. 30,1929 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 1**X**M 2□F 220-16-4883 Alabama Director Usual Residence of Decedent 10c. City, Town or Location Parkville 10d. Inside City Limits Baltimore Mary land item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 2824 Cub Hill Road U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Peacetime¹□Yes 2♥No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Electronic Engineer N.S.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental F 7 is marked oti Be Alexion Alice Christ Camberis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2824 Cub Hill Road Baltimore, MD 21234 19a. Informant's Name/Relationship *(Type, Print)* Mrs. Evangeline Alexion - Wife jes 1 and 2 st it of Health ar t: If item 27 if ry or other tr 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Demetrios Centery 3/4/05 Baltimore, MD permit. Page Department of Important: If any injury or once. '4 □ Donation 5 □ Other (Specify)

21. Signatur 1 F heral Service Licenspe Baltimore, Maryland 21214 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part . Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asphyxiation Pnysician minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** airway obstruction minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a prisequence of) ed by the attending physician and detached for use as the burial-transit i creased muscul 1ears Due to (or as a consequence of): jears Physician/Medical arrin sonism IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an certificate has b irector, page 2 sl autopsy perform 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 455/15+20 LIVING Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2. No 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. • Funerel Director: A 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospitel or At 24 hours after of 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated. the the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20 04556 8 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) BALT 9524 EBRIGH BRADFORD 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nol-1. Decedent's Name (First, Middle, Last) 2. Date of Death MONTH **Physician** Year LLOYD ABRAMS A. 0600 AM 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE N/A OF MARYLAND MEDICAL CENTER 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. Count 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at Director 1 1 Yes 2 No 10g. Oltizen of What Country? Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White 2□ Married 1 Never Married Baltimore, Maryland 21215-0036 1 □ Yes 2 17 Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced other treumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DD NOT lise retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/ ndustry than ondary (0-12) -63r 5+) marked other er's Name /First Mide f Health and Mental Item 27 ie marked o Method Disposition permit. Pages
Department of It
Importent: If Ite
any injury or of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 23a. Part. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** NECROTIZING PNEUNONITIS WITH ADENOVIRAL Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner SEPTIL SEPTIC SHOCK
Due to (or as a consequence of): D4YS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner The law requires that the death certiticate be executed BILATERAL UNC. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician SARCOIDOSIS WITH PESULTANT RESPIRATORY YEARS be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? respiratory failure with difficult ventlations oxygenations gastrointesting bleeding 3 Probably 1 🗌 Yes 2 🗆 No 4 Unknown tilled in by the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No CMV infection, adenuised intertion, new formound infection renal 24a. Was an has autopsy performed?
Yes 2 No Squere mainimitate turgenia, innuposoppossive mall this certificate 25. Was case referred to medical J ☐ Yes Hospitel or Attending Physician: 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending investigation 1 Yes 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 44176439 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUSAKARE 237 W. LANVALE ALAN 0 ST. BALTIMORE, MD 31. Date filed (Month, Day, Year) **B**gistrar's Signature State MAR 03 2005 Registrar

			1 _ For	State of Mar			lealth and l	Mental Hygi	200				
			Registrar 1. Decedent's Name (First, Middle, Last)	·-	Cei	rtilicate of t	Jean	2. Date of Deatl	g. No.C. U (3. Time of Death			
	Physicia		Anna Amer	eihn				Sebruar	Day	Year 10 107			
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or			4c. County o	f Death			
			205 EVANS AVENUE				ONVILLE			EN ANNE			
	Funeral		5. Social Security Number 6. Sex	7. Age (i	In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7-4-191	Year)	Birthplace (State or Foreign Country) MADXIT AND			
	Director		215-68-1605 Usual Residence of Decedent					7-4-191	3	MARYLAND			
	nyland how		10a. State 10b. County		0c. City, Town or Lo					10d. Inside City Limits			
	8e-1 s	cto	MD BALTI	MORE			EDALE			1 ☐ Yes 2 ZMo			
	with th	Funeral Director	10e. Street and Number 1217 RUSTIC AVEN	TIE		10f. Zip Code	1237	10	g. Citizen of Wi	hat Country? U.S.A.			
	ns 23	eral		2. Was Decedent Eve	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		specify Yes or No-	14. Race	- American Indian,			
മ	after d		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		If Yes, specify Cuba 1 □ Yes 2 🛣 No	n, Mexican, Puerl Specify:	to Rican, etc.)		, White, etc.			
03	ural', c	d by	3 XWidowed 4 □ Divorced	Year or Dates:					Specify:	WHITE			
<u>5</u>	n 72 h *natu	lete	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	rking	l6b. Kind of Bus	iness/Industry			
12	withir iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OMEMAKER	,		OM:	IN HOME			
פ	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene of other than "natural" or items 23a or 28e-f show event, the Medical Examinar must be notified at event,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, N	faiden Surname)			
ylaı	2 should be filed within 72 hours after death with the Marylan and Mantal hygiens is marked other than "natural", or items 23a or 28e-f show is marked other than "natural", or items 23a or 28e-f show eumatic event, the Medical Examinar must be notified at	To	JACOB KLINE				BLANC		OBBS)				
Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Headilb and Mentis Important: If item 27 is marked any injury or other treumatic et once.		19a. Informant's Name/Relationship (Type RICHARD AMERETHN			ng Address <i>(Street a</i>		ural Route Number, WEST VIF		itate, Zip Code) 26761			
	Healt Healt tem 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name of				City or Town, State			
ē	Pages nent of I ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☑ Donation 5 ☐ Other (Specify)	emoval from State		matory or other plac EEMER CEM	ETERY 3	-2-2005	BALTIM	IORE, MD			
Baltimore,	permit. Departm Meporta any inju		21. Signature of Funeral Service License	0/ 7 ~	and the same of th					IERAL HOME			
<u>m</u>	83558		Das	TLV.	2 1:	211 CHESA	CO AVENU	E ROSEL	DALE, ME				
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
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6876	e K	dical	d.	Consess	ve nu	rroov	WY.						
Box 6	The law requires that the death certifica are has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcome of		7			23d. Date	of delivery			
	death e atte	Icla	in the past 12 ponths? 1 Yes 2 No	1 Live birth 2 [∃Ectopic pregnancy ∃ Other (s <i>pecify)</i>			Mont	th Day Year			
0	at the de by the a stached	hys	9 🗆 Unknown	9□ Unknown									
	uires that signed t d be deta	by	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	inderlying cause give	en in Part I.			bute to the cause of death? 3 Probably 4 XUnknown			
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Rec	The law ate has page 2 :	Completed	Charle Charles	June 1011	discus			autopsy	pr ned? de	ere autopsy findings available ior to completion of cause of eath?			
Vital Records,	ician: Th certificate rector, pag	a)	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2 ath (Check only one	0	Yes 200 No			
Ž	nysician: nis certific director,	To B	examiner? 1 ☐ Yes 2 KNo	ospital: 1 Inpatient	2 KER/Outpatier	nt 3 DOA Othe	25	lome 5 ☐ Reside		r (Specify)			
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isio	Attending Physician: r death, sctor: After this certifici by the funeral director, I	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home form str		Yes 2□No	28f. Location (Str.	eet and Numbe	r or Rural Route Number,			
Division	a Hospital or Attenc 24 hours after death 8 Funeral Director: etely filled in by the	Certification:	4 Homicide determined	building, etc. ((Specify)	ioot, ractory, cinco		City or Town	State)	or right riodic rearries,			
	ospita hours uneral		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge, deat	h occurred at the tim	ne, date and place	and due to the ca	use(s) and man	ner as stated.			
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	To To	2	29b. Signature and title of certifier	1 m		29c. License	597h	2	428/0	(Month, Day, Year)			
			30. Name and address of person who col	noleted cause of deal	th (Item 23a) (Tyne	Print)	.) / 0		1-4"	.)			
	3		Haron San	_	€	aston, n	0 21	601					
	Sta		31. Date filed (Month ARY, Yoar 3 201	32) legistrar's	Signature								
	Registr	ar		JOSEPH L	15 15	200							

			State of Maryland / Dep	artment of Health and Mental F										
			For	rtificate of Death	Reg. No. 2005 07038									
	Physicia	20	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Day Year									
	/Medic	al	Marian Alston	Febru 4b. City, Town, or Location of Death	1ary 21 2005 2:15 19									
	Examin	er	4a. Facility Name (If not institution, give street and number) Fairland Nursing Home	Silverspring	Montgomery									
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,											
b	Director		229-36-9450 1□M 2\sqrt{\text{MF}} 81 Yrs.	April	12 1923 Virginia									
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits									
	Mary a-f sh	to	Maryland Anne Arundel Annapo	olis	¶ Yes 2 No									
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-f show the Medical Exambrat must be motified at	Direc	Maryland Anne Arundel Annapo 10e. Street and Number 905 Royal St. Apt E 11. Marital Status XXNever Married 2□ Married 1□ Yes 2 X No 1 □ Yes 2 X No 1	10f. Zip Code	10g. Citizen of What Country?									
	s 23a	erai	11 Marital Status 12. Was Decedent Ever in U.S. 13.	21401 Was December of Hispanic Origin? (Specify Yes or	USA No- 14. Race - American Indian,									
"	r Item	Fun	Armed Forces? XXNever Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.									
93	ours a	Ď.	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 🎎 ∰No Specify:	Specify: Black									
Maryland 21215-0036	"netu	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry									
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פ	be filed ital Hygid d other event, II	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid	4									
ylaı	should band Ments s marked umatic e	To	Roland Alston	Levenia Br										
Mar	12 sh h and 7 is m treum			ing Address (Street and Number or Rural Route Nu Royal St. Apt E Anna										
Б	Health tem 27 l			osition (Name of Date matory or other place)	20c. Location - City or Town, State									
OE I	Pages nent of nt: If i			Cemetery 3-3-05	Norfolk, Va									
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or Items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility m. Reese & Sons Mort	tuary, P.A.									
	20599		Larry Liteese MOOY 83	321 West St. Annapol:	is, Md. 21401									
И			Immediate Cause /Final	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
	Physician / /Medical		disease or condition resulting in death) a. Cardiac Arrht Due to (or as a consequence of):	hymia	Instant									
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Вох	death certifical e attending phy ed for use as th	lan/I	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	□Ectopic pregnancy	23d. Date of delivery Month Day Year									
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Vital Records	S S	Completed	Daabetes Mellitus		As an 24b. Were autopsy findings available prior to completion of cause of death?									
a H			Respiratory Failure	1 □ Ye	s 2x No 1 Yes 2 No									
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Division	after of Direct	Certification;	3 Suicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		Town, State)									
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	the Ho in 24 the Fu ipletely	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	-										
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) February 25 2005									
,	h d1		30. Name and address of person who completed cause of death (Item 23a) (Type	D28656	restuaty 25 2005									
	.7		Dr. Ravi Passi 15225 Shady Gro	ove Rd. Ste. 208 Roc	kville Md 20850									
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	rife!	TIVE EUU DU									
	Registr	ar	MAR 0 3 2005 Januar 20 19											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death BELL :30 AM **Physician** ANCHE /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9356 Town Baltimore ()wings Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min 89 214-40-8318 Yrs Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limy(s permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglenia. International the International Internationa 1 Yes 2 No Baltimore Funeral Director 10g. Citizen of What Country? 10e. Street and Number 21117 rive Was Decedent Ever in U.S. Armed Forces 1 Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3. Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ondary (0-12) College (1-4or 5+) eacher 6 yrs 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number r or Rural Route Number, City or Town, State, Zip Code) bishburn (Niece MD lown 20b. Place of Disposition (Name of c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility Vauges Greene Funeral SNCS KC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lic Cardio Vasculas Disease **Physician** /Medical **Examiner** Sinu 510 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 🗹 No. 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? After this certificate 2 No 1 TYes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March Ave Baltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMBANDAM BASKARAN 3438 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			State of Maryland / Dep	partment of Health and Mental	Hygiene	
			1 - State Registrar C6	ertificate of Death	Reg. N G. 005	07040
ı	Physici		1. Decedent's Name (First, Middle, Last) Mathilda Marcella Bisa		of Death h Day Year YUN V 28 20	3. Time of Death
	/Medic Examin	45	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	c. County of De	ath
	14.		5. Social Security Number G. Sex 7. Age (In yrs. last birthday	OYKESVIILE If Under 1 Year If Under 24 Hrs. 8. Date of	of Birth	irthplace (State or Foreign
	Funeral Director		171 16 0081 1 M 2 K 88 Yrs.	Months Days Hours Min. Apri-	h, Day_Year) (insylvania
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	Aaryla I shov	ō		Dealion		1 Yes 2 No
	r 28e-	rect	Maryland Baltimore Essex 10e. Street and Number	10f. Zip Code	10g. Citizen of What (
	23a o 23a o ust be	alD	610 Delaware Avenue	21221	USA	
	ltems	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- 14. Race - An Black, Wh	nerican Indian, nite, etc.
036	72 hours after death with the Maryland naturel', or Items 23a or 28e-1 show drail Examiner must be recitified at		3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2X No Specify:	Specify Wh:	ite
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121	within iene. than "	ldui	Elementary/Secondary (0-12) College (1-4or 5+)	Sales Clerk	Retail	Sales
	illed Hygie other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M		bares
/lan	should be nd Mental marked o	To B	George Rusinak	Elizabeth	n Maderas	S
Maryland	and and Is m		1	iling Address (Street and Number or Rural Route N		
	1 and Health tem 27 other tr		20a Method of Disposition 20b. Place of Disp	Hawthorne Road Middle Position (Name of Date	20c. Location - City of	
E O	Pages nent of int: if it		1 Ki Buriat 2 Cremation 3 Removal from State	ematory or other place) nilaus Cemetery 3/5/2005	5 Baltimore	Maryland
Baltimore,	permit. Pages 1 al Deportment of Hea Importent: if item any injury or othe once.			22. Name and Address of Facility Bruzda	zinski Funera	1 Home PA
8	89 2 2		The Day	1407 Old Eastern Avenue		
Ш	\$:		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shook, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respirat	ory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a			days
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9	ing phy a as th		IF FEMALE:		I	
Вох	death certific e attending p id for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	23d. Date of d Month	elivery Day Year
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ord	w require been sig should b	Completed by	Cerebrovascular accident	1		Probably 4 Unknown
3ec	e law has b je 2 sł	mple	dementia		Was an autopsy performed? 24b. Were a prior to death?	autopsy findings available completion of cause of
Vital Records,	ysicien: The Is certificate hadirector, page	e Co	25. Was case referred to medical	1 ☐ \	Yes 2.2 No 1 □ Ye	es 2 No
		To B	examiner? 1 Yes 2 No	Othor	Residence 6 □Other (Sp	pecify)
n of	ding Ph h. After th funeral		27. Manner of Death 1. ■ Natural 5 □ Pending	Work?	cribe how injury occurred	
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Σ	al or A s after I Dire	Certification:	4 Homicide determined building, etc. (Specify)		or Town, State)	
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the deal of the pass of examination and/or and manner stated.	ath occurred at the time, date and place, and due to investigation, in my opinion, death occurred at the	the cause(s) and manner a time, date and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	nth, Day, Year)
			Mate 4/6 mg	DO058137	3/1/0	5
	4		30. Name and address of person who completed cause of death (Item 23a) (Type Crilbu Kus 295 Stone Are	9, Print)	3/110	2050
	Sta	ite	31. Date filed (Month, Day, Year) MAR 0 3 2005	Sparle	., ., .,	<u> </u>
	Regist	ar	MAR 0 3 2005	11		

			For State Registrar	State of M	aryland		artment of H tificate of L				iene) ()5	07041
	Dhyala		Decedent's Name (First, Middle, Last			· · · · · · · · · · · · · · · · · · ·				ate of Death		Year.	3. Time of Death
	Physici /Medi		Marie Cather								27 20	505	2:41HM
	Examir	ner	4a. Facility Name (If not institution, give	uare	H05	Pital	4b. City, Town, or	C d (2/2		4c. County	1+	1m6/e
н	Funeral Director		5. Social Security Number 6. S 215-12-3331	ex □M 2 X F	8 8	ast birthday) Yrs.	Months Days	Hours	Min. Ju	te of Birth fonth, Day,	Year) 1916	9. Birthp Cour Man	place (State or Foreign ntry) ULAND
			Usual Residence of Decedent								, , , , ,		
	show	J.	10a. State 10b. County		10c. City	, Town or Lo	cation	D D	45			1	10d. Inside City Limits 1 ☐ Yes 2 X No
	the M	Director	Maryland Baltim	ore	L		10f. Zip Code	bac	timore	10	g. Citizen of W	hat Cour	
	3a or		1 A Raylon Driv	ρ.			101. Zip 0000	2	1236		u.s.		nuy.
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13. V	Vas Decedent of Hi Yes, specify Cuba			es or No-	14. Race	- Americ	can Indian,
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "netural", or itams 23e or 28e-f show event, the Medical Evant extrinst be recitied at	by	1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	1 Tes 2 XI If Yes, Give Year or Dates:			Yes 2 No	Specify:		, etc.)	Specify:	k, White, Whi	
5-0	72 ho netur iicul	Completed	15. Decedent's Ec	fucation de completed)		16a. Deced	lent's Usual Occupa	ation during mos	t of working	1	6b. Kind of Bus	siness/Inc	dustry
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Maryland	2 should be filed withir and Mental Hygiene. Is marked othar then eumatic event, tre M	To Be	George Denk					Мо	vrgaret	Kahl	ler		
Mar	s 1 and 2 should F Health and Meritem 27 is marke other treumatic	1	19a. Informant's Name/Relationship (19mm). Patricia Rai		onl		g Address (Street a Kilbride				,	State, Zip 1236	Code)
	s 1 and 2 if Health item 27 other tre	П	20a. Method of Disposition	<u> </u>	20b. Pla	ace of Dispos	sition (Name of	· ·	Date	7	0c. Location - 0		own, State
OE .	0 = 0		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify				natory or other place Mem'l Pa	·	3/2/2003	5 E	Baltimo	no. I	Maryland
Baltimore,	permit. Pag Department Important: any injury conce		21. Signature of Funeral Service Licen	0008		22.	Name and Addres	s of Facilit	y Schimu	inek t	uneral	Hom	
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused	the death.							230	Approximate Interval Between
4	Pnysician		Immediate Cause (Final disease or condition	Fall	10.				,	W.	Sr. /	~	Onset and Death
8	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):			Se	10	E.		- Pre-CID
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I^{-}	nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	erice or).			0/0	$L^{'}$ \times_{6})		
,	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):		Y	$\lambda \gg \lambda_{p}$	7.7			
8760,	cate be executed bhysician and the burial-transit	dlcal		d						<u> </u>			
9		Med	IF FEMALE:				<u> </u>			-			
Вох	The law requires that the death certifit te has been signed by the attending p tage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3 🗌	Ectopic pregnancy	_ / ,	\ \sum_{1}		23d. Date Mont		ery Day Year
<u>o</u> .	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ath 5∐	Other (specify)	1/					
<u>α</u>	that the seed by detact		Part II. Other significant conditions of	ontributing to death b	ut not resul	Iting in the un	derlying cause give	n Part I.	23	3e. Did toba	icco use contrib	oute to th	ne cause of death?
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of \	Physician: this certific ral director,	2	1 ✓ Yes 2 □ No	Hospital: 1 Inpatie		R/Outpatient		4 🗀 1401	rsing Home 5				1)
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	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical C	29a. Certifier (Check only one) Certifying Ph. 2 Medical Example 1	ysician: To the best of tiner: On the basis of and manner sta	of my know examination	ledge, death	occurred at the time	e, date and inion, deat	d place, and du	e to the cau	ise(s) and mani	ner as sta	ated.
	To the vithin 2 To the complex	Me	29b. Signature and title of certifier	- /			29c. License	number		290	d. Date signed	(Month, L	Day, Year)
	, ,,,,		> Wassin E	4714-1	r	N	DC	1)2	1		1/28	105	
	6		30. Name and address of person who	1 1 1 A			•		000	0	.7 4	0	
	6		Dr. Wossin El-1	11+1:9000	srlo	>UK1	insolu	ale	Priv.	e Ba	-Himos	e,n	VD 5153)
	Sta Registr	4.5	31. Date filed (Month, Day, Year)	32. Registra	ars Signatu	As As	ode					,	

State of Maryland / Department of Health and Mental Hygiene For Stata Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Blair March /Medical 2005 0500 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Agnes Saint Heal theare Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) October 15, 1935 **Funeral** Birthplace (State or Foreign Country) Months 1 ☐ M 2 💢 F 216-32-3916 Director 69 Yrs. MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location or 28a-1 show 10d. Inside City Limits traumatic evant, the Medical Examiner must be notified at MD. Baltimore Completed by Funeral Director Middle River 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 530 Compass Road 21220 Itams 23s USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 5 Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years **HOusewife** Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marvin Edgar Crouch Sr. Grace Lillian Koppleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar trat <u>once</u>. Robert Blair Husband 530 Compass Road, Middle River, MD. 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 5, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery `4 ☐Donation 5 ☐ Other (Specify) 2005 Dundalk, MD. 21 Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 21222 Park. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Small CANCER disease or condition resulting in death) Non 2 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? Diractor: After 28d. Describe how injury occurred 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) a Funeral Dirac 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD P17-601 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DetHoff Baltimore, Kristine 900 S. Calon Avenue 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 03 2005 graver) Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** February 28 2005 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE Johns Hopkins
Curity Number 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 32561298 Days Months Hours Min 1 □ M 2 🕶 🗜 Director -13-WEST YIRGINIA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10f. Zip Code ō B-2 5.A Itams 23E IRCLE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ges 1 and 2 should be filled within 72 hours after it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced HITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILMA BLANCHARD Smith JAMES J. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) illiam BERRY PASADENA, MD Z1122 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Seremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 21. Signatur 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, PA 231 Part1. Enter the 2601 Mountain Road - Pasadena, MD, 21122 disease, f confailure. Lit only complication that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only the content of Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final Physician Sepsis MONHIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 ificate has 2 No 1 □ Yas of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Ble 26. Place of Death (Check only one) Cer Hospital: 2 1 🗌 Yes 2 🖸 No 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA this feneral 28c. Injury at Work? 27. Manyer of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a ical 29a, Certifier 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Name and address of person

31. Date filed (Month, Day, Year)

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2005

of death (Item 23a) (Type, Print) lowth Wolfe RES-000

Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ () 5 1 - For Stete Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2005 MARCH 1, **Physician** BAUM JACK 7:50 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 9, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□ F Months Days Hours Min 073-26-2145A Yrs. Director 89 POLAND Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits нет z.r re marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT #528 21117 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🕅 No Specify: WHITE δ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **FURRIER FURS** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F SHAYA CWAIJBAUM SHATNDFL HEISMAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 I 12138 HENESON GARTH - OWINGS MILLS, MD 21117 SHERYL REICHER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK!03/02/2005 RANDALLSTOWN, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lisensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final nex **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner nding physicien and use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the atter in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 2 CNo 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) NOSFCG 1 ☐ Yes 2 № No 1 | Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ofter death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) Baltunoe on worles rendes an 600 21. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 3 2005

	1		State of Maryland / Department of Health and Mental Hygiene 1- State State Certificate of Death Reg. No.2 0	15 07015
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death FERRUARY 28	Year 3. Time of Deal An)
	/Medic Examin		er 4a. Facility Name (If not institution, give street and number) NONTHWEST HOSITAL CENTER RANDALL STOWN 4c. County o	
	Funeral Director		5. Social Security Number 213-05-1059 Output 6. Sax 1	9. Birthplace (State or Foreign Country) RUSSIA
	Maryland -1 show lied at	tor	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2X No
	or 28a)irec	10e. Street and Number 10f. Zip Code 10g. Citizen of Wi	hat Country?
	ath w	ral	7920 SCOTTS LEVEL ROAD 21208 U	.S.A.
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-1 show other traumatic event, Item Medical Estational to confide a	by Funeral Director	3 Widowed 4 Divorced If Yes, Give 1 Yes 2 VA No Specify: Specify: Specify:	- American Indian, , White, etc. WHITE
15-0	"natu	letec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (16b. Kind of Bus	iness/Industry
21215-0036	d withingiane.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) FURRIER / PROPRIETOR RETAIL	FINE FURS
Maryland	should be filed ind Mental Hygis s marked other umatic event, I	To Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19. MIDIAM	GERSHENSON
	1 and 2 sho Health and I Iem 27 is ma		19a. Informant's Name/Relationship (Type, Print) SANDI GILBERT / DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 2-B DORSET HILL COURT OWINGS MILLS,	. ,
Baltimore,	permit. Pages 1 an Department of Heali Important: If item 2 any injury or othar Once.		20a. Method of Disposition 1 Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Disposition 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) KOVNA CONG. CEMETERY 03/02/2005 BALTIMO	RE, MD
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BR 8900 REISTERSTOWN ROAD - PIKESVIL	
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Conus 297 IN E DERT FAILNRE	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of): CORONARY ARTERY DISERSE:	
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	w requires that been signed b should be deta			oute to the cause of death?
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	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical		nd due to the cause(s)
	To CO	-	D42723 FEARURR	
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORT A CUEST 14 STIT ROAD STORM RISH S401 OLD COUNT ROAD STORM RISH S401 OLD COUNT ROAD STORM RISH S401 OLD COUNT ROAD STORM RISH STORM	D WD 71133
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death v 28, **Physician** February 2005 Buchanan, Sr. Floyd L. 15:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Dec. 27, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 77 217-22-0734 Yrs. Director Pennsylvania Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Itam 27 is marked other than "netural", or Itama 23s or 28e-1 show other traumatic event, the Medical Examination rule for multipolat 10d. Inside City Limits Maryland Harford Co. Abingdon 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , jo 283 Maple Wreath Court 21009 United States death Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 ØYes 2 □ No 1947= 17 Yes, Give Year or Dates: 1040 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: White 3 Widowed 4 □ Divorced 1949 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Body & Fender Shop 6 yrs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Wilbert Buchanan Stombaugh Ida 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 is rr any injury or other traurr <u>once.</u> Mrs. Susan A. Gargano /Daughter 283 Maple Wreath Ct. Abingdon, MD 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State * 4 □Donation 5 □ Other (Specify) Meadowridge Mem. Park 3/04/2005 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Michael E. Canapp 110 Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dalmerali Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a c Examiner (sequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Tyes 27 No 1 Inpatient ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) Manner of Death Certification: 8b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred tha Hospital or Attending 1 Natural 5 Pending death. 2 Accident investigation M 1 Yes 2 No Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name on who completed cause of death (Item 23a) (Type, Print) han 500 Upper Chesapeake Drive Bel Air, MD 21015 ettre 31. Date filed (Month, Day, Year) State

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Registrar

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			1 - State Registrar		/ Department of F	lealth and Mental Death	Hygiene 0	05 0704
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Virgin 4a. Facility Name (If not institution, give str MARINER HEAL		4b. City, Town, o	2. Date of Month	Day	Year 9 9 A N
	Funeral Director		5. Social Security Number 220-03-4260 Usual Residence of Decedent	7. Age (In yrs. las	Yrs. Months Days	Hours Min. Sept.	i, Day, Year)	9. Birthplace (State or Foreig Country) Maryland
	72 hours after death with the Maryland neturel', or items 23a or 28a-f show alteal Examirae must be notified at	Funeral Director	Maryland Harford 10e. Street and Number 410 E. MacPhail Roa	Bel A	Town or Location Air 10f. Zip Code 21014		10g. Citizen of W	10d. Inside City Limit: 1 X Yes 2 □ No //hat Country?
9600	hours after death urel', or items 2 Il Examirer mu	Ď	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 📉 No	ispanic Origin? (Specify Yes o in, Mexican, Puerto Rican, etc Specify:	r No- 14. Race Black Specify:	White
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Baltimore, N	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other treumstic event, Ite Maralcal Examiner must be notified as any once.		Teresa M. Furst - I 20a. Method of Disposition 1 Burial 2 Ocremation 3 Ren 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee	20b. Plac cern	222 Golden Ra ce of Disposition (Name of netery, crematory or other place Ltop Service C 22, Name and Addres McComas F 1317 Coke	Date	Towson	City or Town, State Maryland
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	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	29a. Certifler (Check only one) 29b. Signature and title of certifier	an: To the best of my knowle : On the basis of examination and manner stated.	edge, death occurred at the timen and/or investigation, in my op	ie, date and place, and due to pinion, death occurred at the life	ne, date and place, ar	nd due to the cause(s)
	P in Co	-	30. Name and address of person who comp	/	D25 Ga) (Type, Print)	227	2/31	(Month, Day, Year)
	Sta Regist		PATRICIA DUSY: 31. Date filed (Month, Day, Year) MAR 0.3 2005	32. Registrar's Signature	. , , , , , , , , , , , , , , , , , , ,	KL bel Air Mo	21xy	
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			For State Registrar	State of Maryland		rtment of H			iene 005	07048
	Physici	an	Decedent's Name (First, Middle, Last)	I Bo	- ha			2. Date of Dear	Day Yeer	3. Time of Death
ı	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	<u>u na</u>	4b. City, Town, or	r Location of Dea	th Tenrua	4c. County of Dea	
			5. Social Security Number 6. Sex	n ham Re 7. Age (In yrs. la	act	If Under 1 Year	If Under 24 Hrs	S. 8. Date of Birth		nore (o.
	Funeral Director			M 2□F 75	Yrs.	Months Days	Hours Min		, Year) C	rthplace (State or Foreign ountry) aryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-f she	ctor	Maryland Harfo	rd			Edgew	vood		1 ☐ Yes 2 承No
	with the	Director	10e. Street and Number 1809 Sandee Cou			10f. Zip Code	07.0		0g. Citizen of What C	•
	death ms 23,	eral		2. Was Decedent Ever in U.S	3. 13.	Vas Decedent of H	2104 ispanic Origin? (Specify Yes or No- rto Rican, etc.)	United S 14. Race - Am	erican Indian,
36	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or ttems 23a or 28a-f show ant, the Modical Examination must be notified at	by Funeral	1 ☐ Never Married 2☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XXes 2 □ No If Yes, Give Korea; Year or Dates:		ryes, specny Cuba I∐ Yes 2∑∏ No	Specify:	no Hican, etc.)	Black, Wh Specify:	white
Maryland 21215-0036	2 hour atural' ical Ex	ted b	15. Decedent's Educ	cation	16a, Deced	lent's Usual Occup	ation		16b. Kind of Business	
215	vithin 7 ne. han "n	Completed	(Specify only highest grade	College (1-4or 5+)	lite. L	kind of work done o	1)	orking		
0 0	filed v Hygie other t ent, th	Be Co	8 Years 17. Father's Name (First, Middle, Last)	1		Steelwor		ame (First, Middle, I	Steel I: Maiden Sumame)	ndustry
ylan	should be ind Mental i marked c	To B	Paul Conrad Lun	ger			Marga	ret Ruth	Brushwill	er
Mar	d 2 sho th and th sm 7 is m traum		19a. Informant's Name/Relationship (Type Mrs. Nancy L. B.			g Address (Street) Sandee (Rural Route Number rewood, Ma	r, City or Town, State,	Zip Code) 1040
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It's Modical Examination and injury or other traumatic event, It's Modical Examination and injury.		20a. Method of Disposition	^a	ace of Dispo	sition (Name of natory or other place	1		20c. Location - City o	
Baltimore,	Pages tment of I tant: If Its		1 Burial 2 Cremation 3 R Donation 5 Nother (Specify)	Entombment	Holly	Hill Mem	. Gans.	3/2/2005	Middle B	iver, MD
Ba	permit. Departr Import any infi		21. Signalule of Funeral Service License	Can OC	7 22				Dundalk,	
Ė		-	23a Part. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death e cause on each line.	. Do not ent				Maryland est,	Approximate Interval Between
E	Pnysician		Immediate Cause (Final disease or condition resulting in death)	Conges	tive	· Hea	at F	ailure	2	Onset and Death
ı	/Medical Examiner			Due to (or as a s nsequ	ence of):					
	D its	iner	Sequentially list conditions, if any, leading to immediate cause fair of Jarrying Cause (Disease or injury	Due to (or as a consequ	ence of):					
	execute	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequ	ence of):					
8760,	cate be executed oblysician and the burial-transit	cal								
9	certifica ding pt se as t	Physician/Medical	IF FEMALE:	3c. If yes, outcome of pregnar	nev				074 Data of 44	
. Box	The law requires that the death certific tre has been signed by the attending p bage 2 should be detached for use as:	ician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
<u>Р</u> .	hat the d by th letache	Phys	9 ☐ Unknown Part II. Other significant conditions con	9∐Unknown	Iting in the Lu	dochring on use and	on in Part I	23a Did to	bacco use contribute t	o the cause of death?
ds,	uires the signer of the control of t	by	Fatti. Other significant conditions con	minuting to death but not resu	ing in me u	idenying cause giv	enin rauti.	1 🗆 Ye		robably 4 Unknown
ecol	e law requir has been si je 2 should	Completed						24a. Was a autops	n 24b. Were a	utopsy findings available completion of cause of
a E								perform	med? death? 2⊠No 1 ☐ Ye	_
Division of Vital Record	S S	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien	t 3 DOA Oth		eath (Check only on Home 5 Reside	ence 6 ØOther (Spe	acity) Residence
0 L	ing Phys After this uneral di		27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	y at k?	-	ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
/isic	Attending it death. ector: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, str		Yes 2 □No		reet and Number or F	lural Route Number,
á	ital or A irs after ral Dire	Certi	4 Homiciae	building, etc. (Specify				City or Town		
	To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier Certifying Physical Check only one)	sician: To the best of my know ner: On the basis of examinati and manner stated.	viedge, death ion and/or inv	occurred at the ting estigation, in my o	ne, date and place pinion, death occ	ce, and due to the co curred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1		29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)
	4 - 1		1 Cox 1.	w	•		550	35	2/28/0	5
	5+1		30. Name and address of person who co	mpleted cause of death (Item	_		och R	leven Bl	vd. Batt	SICIE and o
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	-	1.10.			1	y Alai O
	Regist	ar	MAD 03 20	1115 Ballona	11. 1	TO BELLEVILLE				

DHMH 17 Rev 1/2001

			1 - State Amend Item	State of Mar 23a per Dr	yland / De G841, 2	partment of H 3/03/05dhb erifficate of	lealth and M Death	ental Hygier	005	07049
	Dhysisi		1. Decedent's Name (First, Middle, La	st)				2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		RUSSELL I	BIDDLE SR	•			Tarri	5 2009	- 1810 M
	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death	4	tc. County of Dea	th
			UNION MEMORIAL 5. Social Security Number 6. S		In yrs. last birtho	BALTIM av) If Under 1 Year	ORE If Under 24 Hrs.	8. Date of Birth	N/A	
	Funeral Director		1	(X) M 2□F	67 Yrs	Months Days	Hours Min.	(Month, Day, Yea	ir) G	thplace (State or Foreign ountry)
			213-32-7138 Usual Residence of Decedent		0 /			JAN 2 193	8 MA	RYLAND
	how		10a. State 10b. County	1	0c. City, Town o	Location				10d. Inside City Limits
	e Ma	cto	MARYLAND N/A		Е	ALTIMORE				1 X Yes 2 No
	ith th	Director	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Co	ountry?
	s 23a		4147 EIERMAN			212			J.S.A.	
98	s I and 2 should be filed within 72 hours after death with the Maryland Fleatth and Mental Hygiene. It health and Mental Hygiene. It amarked other then "netural", or Items 23a or 28a-f show other traumatic event. It a Medical Ever it at most be redified at	/ Funerai	11. Marital Status 1 □ Never Married 2 → Married	12. Was Decedent Even Armed Forces? 1 ☐ Yes XX No tf Yes, Give	er in U.S.	 Was Decedent of H. If Yes, specify Cuba Yes 2 X No 	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
00	hours ural',	d by	3 Widowed 4 Divorced	Year or Dates:	1000				Specify: BL	
21215-0036	"net	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)	(G	ecedent's Usual Occupa ive kind of work done of e. DO NOT use retired	during most of workii	ng 16b.	Kind of Business	/Industry
12	withi	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		RRECTIONAL			MD STATI	ъ.
	e filed within at Hygiene. I other then '	Be C	17. Father's Name (First, Middle, Last)					(First, Middle, Maid		
an	should be nd Mental marked o	To B	GEORGE BIDDLE				MABEL			
Maryland	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street a	and Number or Rura	Route Number, City	or Town, State,	Zip Code)
Σ	1 and 2 Health a am 27 is		Gwendolyn Beal/Da	ughter	20	Plater Ct	. Balting	ore. Maryl	and 2120	7
ore	ges 1 of He or oth		20a. Method of Disposition 1XXBurial 2 Cremation 3		20b. Place of Di	sposition (Name of crematory or other place	D	ate 20c.	Location - City or	Town, State
Ë	Pag ment ant: lury c		`4 ☐ Donation 5 ☐ Other (Specif		MT ZIO	N CEMETERY	02-11-	-05 LAN	ISDOWNE,	MARYLAN
Baltimore,	permit. Pages 1 am Department of Heali Important: If itam 2 any injury or othar 2002.		21. Signature of neral system Lines	NOULLI		22. Name and Addres WILLIAM C 1 1206 W NO1	BROWN COM		NERAL HON	ME P.A.
	Dhysisian		23a. Part Enter the disease, or com shock, or heart failure. List only tmmediate Cause (Final	one cause on each line.		enter the mode of dyin				Approximate Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	a. MUTS4572 n		Failure	-			ZWEKS
	Examiner		Conservation to the state of th	n Pancreatin	. ,					Bueus
	D .≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c						
	acute ind transi	Examiner	Cause (Disease or injury that initiated events	c. F = 0 w 1	- Acces 6 to 2					monia
90,	oe exe cian a urial-	Ë	resulting in death) Last	Due to (o sa d	,					1 month
38760,	icate be executed physician and the burial-transit	dicai		d. DOELHAA	ve's Sy	ROLOHE				1 month
.O. Box 6	that the death certific. ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at tin	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year		
<u>α</u>	res that t igned by be deta		Part II. Other significant conditions of	ontributing to death but i	not resulting in th	e underlying cause give	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
rds	quires n sign	d by						1 ☐ Yes	2 ₽ No 3□Pr	obably 4 DUnknown
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy performed?	prior to death?	stopsy findings available completion of cause of
Vital	iclan: Th certificate rector, pag	Ö	25. Was case referred to medical				26. Place of Death	(Check only one)	lo 1 Yes	2.2 No
	8 v =	OB	examiner? 1 🗌 Yes 2 🍱 No	Hospital: 1 Inpatient	2 ER/Outpa	tient 3 DOA Othe	000	ne 5 Residence	6 □Other (Spec	cify)
on of	ding h. Afte fune	tion; T	27. Manner of Death 1 Panatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Tim	e of 28c. Injury Work		8d. Describe how inj		,,
Division	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: Afte completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	9	- At home, farm, Specify)	street, factory, office		8f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
J	Hospital		29a. Certifier 15 Certifying Ph	ysician: To the best of r	ny knowledne d	eath occurred at the "-	ne date and place of	nd due to the course	e) and marror	stated
	To the Hospital within 24 hours a To the Funeral Completely filled	Medicai	(Check only 2 Medicat Examone)	niner: On the basis of example and manner states	camination and/o	r investigation, in my or	pinion, death occurre	d at the time, date a	nd place, and due	to the cause(s)
	with To	-	29b. Signature and title of certifier	2		29c. License			ate signed (Montl	
			1 yro			AT24	55946	1-06	suary 03	, 2003
_			30. Name and address of person who Stuces T Shindel				Timore i	nD 2/218	?	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 3 2005	20/ E. Univer	Signature Are	di				
			HIMI O O COOJ	The state of						

Physicia /Medica		State of Maryland / Dep State Amend Item 5 per FH, G841, 03/09/6	Timodio oi Bodiii	R	eg. No. UU5	-0.705				
		Decedent's Name (First, Middle, Last)	T	2. Date of Deat Month	th Day Year	3. Time of Death				
AMEGIC		REXFORD OWEN BITTINGER	, JR	02	27 200.	5 07:13 P				
Examine	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea					
		1919 PORTOBAGO LANE	HANOVER If Under 1 Year If Under 24 Hrs.			RUNDEL				
Funeral Director		5 Social Security Number 6. Sex 7. Age (In yrs. last birthday 2 F 69 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, MAY 18,	Year) C	thplace (State or Fore ountry) nsylvania				
* -	-	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or L	ocation			10d. Inside City Lim				
a or 28a-f show	5	MD Anne Arundel Hanover,				1 □ Yes 2 □				
28a	Funeral Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	ountry?				
38 0	0	1919 Portobago Lane	21076		USA					
ms 23	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame					
0	by Fu	1 Never Married 2 Married 1 MYes 2 No 1 Widowed 4 Divorced If Yes, Give National	1 ☐ Yes 2 ☒ No Specify:	nican, etc./	Black, White					
"netural",	Completed	15. Decedent's Education 16a. Dece	edent's Usual Occupation		16b. Kind of Business	/Industry				
	ple	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing	Guard Rails	5,				
/gien er th	Co	12 Con	struction Superint	endant	Etc. Inc.	•				
d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		Maiden Surname)					
t of Health and Mental Hygi If item 27 is marked other or other treumatic event.	ပ္	Rexford Owen Bittinger, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Mary Mil		City of Town State	Zio Co dol				
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of Health a fitem 27 is r other tre	-	20a. Method of Disposition 20b. Place of Disp	Portobago Lane, Hosition (Name of		MD 21076 20c. Location · City or	Town, State				
y or o		1 🔀 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	emetery 3/4/2		Friendsvill					
Department of Himportent: If ite any injury or of once.	Ī	21. Signature of Funeral Service Licensee	2. Name and Address of Facility arv L. Kaufman Fun	eral Hon	ne @ Meadowr	cidge Mem.				
	-	23a. Part1. Enter the disease, or complications that caused the death. Do not en	<u>250 Washington Blv</u>	d., Elkr	cidge, MD	21075 Approximate				
		snock, or neart failure. List only one cause on each line.			551,	Interval Between Onset and Death				
nysician Medical		disease or condition resulting in death) a. HCUTE /NYO CAR!	SIAL INFARCTI	ON		< 1 DAY				
xaminer		Sequentially list conditions b. Coronary Antery Disease								
.Al.	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that bitted exerts.	cry - wenze			-1121				
ransit	Examiner	trial initiated events	ELLITUS			Z YRS				
ien ei urial-1	EX	resulting in death) Last Due to (or as a consequence of):								
physicien end s the burial-transit	dicai	d								
a attending pi	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy								
attend for us	ian/	in the past 12 months?	□Ectopic pregnancy		23d. Date of de Month	ivery Day Year				
90	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)							
는 등	/Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?				
detach	0	HYPENTENSION		1 □ Ye	s 2XNo 3□Pr	obably 4 Unkno				
n signed by the	d L	,		24a. Was ar	n 24b. Were au	itopsy findings availa				
s been signed by the attending physicien end should be detached for use as the burial-tra	leted k				y prior to	completion of course				
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his certificate has b il director, page 2 sh	To Be	examiner? 1 Yes 2 No	ont 3 DOA Other: 4 Nursing Hor	perform 1 Yes 2 (Check only one me 5 Reside	No 1 Yes	2 No				
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n. After this certificate has b funeral director, page 2 sh	Certification: To Be	examiner? 1 Yes 2 No 1 No Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier Acartha (Month, Day Year) 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Place of Injury · At home, farm, si building, etc. (Specify) 29c. Certifier (Check only one) 29d. Signature and title of certifier 29d. Signature and title of certifier	of 28c. Injury at Work? M 1 Yes 2 No reet, factory, office th occurred at the time, date and place, restigation, in my opinion, death occurred. 29c. License number D 2 2 8 3 Z	perform T Yes 2 Check only one S Reside 28d. Describe ho 28f. Location (Str. City or Town and due to the caed at the time, da	No 1	2 No cify) Iral Route Number, I stated. I to the cause(s) h, Day, Year)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 February Charles Cook /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Square Ho Roseda Baltimore bita enter Franklin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. Yrs. Director 230-38-2755 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28e-f show treumatic event. The Madical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Items 23a Completed by Funeral 44 Oak Grove Drive Apt. <u> 21221</u> Α. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ō If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 X Divorced 1967 White "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 8 Mechanic Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James A. Cook Della Lawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an 21162 Health item 27 Lucille Welch (Sister) 10828 Philadelphia Road White Marsh, other Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of i Importent: If it any injury or o once. 3/2 2005 1 Burial Cremation 3 Removal from State ⁴ □ Donation 5 □ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signature of Funeral Service Licensee 50 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lickail 1407 Old Eastern Avenue Essex, Maryland 21221 Immediate Cause (Final disease or condition resulting in death) **Physician** 0006 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2X No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 / Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. 28d. Describe how injury occurred 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 24 hours a Hospital filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tyle of certifier

State Registrar 9000 Franklin

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

DR ANGSTASIOS SOLICATIS 9000 From
31. Date field (Month, Day, Year)

32. Registrar's Signature

2005

			1 - For	State of Mary	land / Depa	artment	t of H	ealth a	and M	-		2005	07050
			Registrar		Ce	rtificate	9 OI L	Jeath	· · · · · · · · · · · · · · · · · · ·		Reg. N	6. 000	01032
н	Physici	an	Decedent's Name (First, Middle, Last)	. 0 1 0 0						2. Date of Do Month		ay Year	3. Time of Death
	/Medic			rldwell		1				March	1,	2005	9:50 A M
	Examin	er	4a. Facility Name (If not institution, give str			1		Location o	of Death		1	County of Dea	
			Oak Crest Care Co				vrkv		24 Mea			Baltimo	
ı	Funeral Director		213-14-4143		yrs. last birthday) 4 Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, Di Oct. 1	rth a <i>y, Year</i> 1, 1		thplace (State or Foreign ountry) NYLAND
	pu *		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation							10d. Inside City Limits
	aryla shor	<u>_</u>			o. Oay, Town of E			0 -					1 ☐ Yes 2 ☑ No
	Ba-f	Funeral Director	Maryland Baltimore	2			evil	<u>ce</u>			40: 0	**	
	vith ti	Ē	10e. Street and Number	1.6.440	a	10f. Zip		021			10g. C	itizen of What Co	ountry?
	ath v	ra.	8820 Walther Blvd.,	`				234				u.s.A.	·
	er de Item	nue		. Was Decedent Ever Armed Forces?	in U.S. 13.	If Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Spe n, Puerto f	cify Yes or Na Rican, etc.)	0-	14. Race - Ame Black, Whit	
36	s aft		1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates:		1 ☐ Yes 2	No 💢	Specify:				Specify: Who	ite
Ş	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28e-f show ther then Medical Examinar must be motified at	Completed by	15. Decedent's Educa		16a Dece	dent's Usua	I Occupa	ation			16h	Kind of Business	Andustry
15	n 72	ete	(Specify only highest grade	completed)	(Give	kind of wor DO NOT us	k done d	furing most	t of workir	ng	100.1	(MIC OF DUSITIOSS	moustry
12	with ene. thar	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)		utive					Fe	rtilize	r Company
9	filed Hygi other		17. Father's Name (First, Middle, Last)	<u> </u>						(First, Middle			, ,
an	2 should be filed vand Menta! Hygie vand Menta! Hygie is marked other is raumatic event, II.	To Be	Thomas O'Neill					Mari	e.	Lottes			
<u> </u>	mari mati	F	19a. Informant's Name/Relationship (Type	, Print)	19b. Maili	na Address	(Street a	and Numbe	er or Rura	l Route Numb	er. Citv	or Town, State, 2	Zip Code)
Maryland 21215-0036	d2sthartharthartharthan		Mr. Kenneth Caldwell	-		_					_		le, MD 21234
ē,	Hea Hea tem		20a. Method of Disposition		0b. Place of Dispo cemetery, cre					ate		ocation - City or	
ē	Pages nent of h ant: If ite ury or of		1 Donation 5 Dother (Specify)		cemetery, cres Gavrison				3/9	/05	Owi	ngs Mil	P. M.D.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examinar must be notified at Once.		21. Signature of Funeral Service Licensee					- 1			1	eral Hor	•
Ba	lmp one		> 1/4/1/M/_									D 21236	nes
			23a. Part1. Enter the disease, or complica shock, or peart failure. List only one	itions that caused the					<u> </u>				Approximate
	Dharisian		Immediate Cause (Firal									1	Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	End 5	tage of	de me	ent	9	412h	eime	5,2	+4p.2	
	Examiner			220 10 101 23 2 001	nooquonoo oi).								
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events c.	Due to (or as a cor	nsequence of):								
$\sqrt{}$	uted d ansit	Ë	cause. Enter Underlying Cause (Disease or injury										
Λ.	be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cor	nsequence of):	· .							
1760,	w = 0	cai	L d.										
89													
Вох	n cert	2	IF FEMALE: 23b. Was decedent pregnant	. If yes, outcome of pr		76						23d. Date of del	ivery
m	death	icia	in the past 12 months?	1☐Live birth 2☐ 4☐Pregnant at time		⊒Ectopic pre ⊒ Other (spe						Month	Day Year
P.O.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	9 🗀 Unknown	9□ Unknown						_			
	es thai igned l		Part II. Other significent conditions contr	ibuting to death but no	t resulting in the u	ınderlying ca	ause give	n in Part I.		23e. Did	tobacco	use contribute to	the cause of death?
rds	quire in sig uld b	be to	hyportension							1 🗆	Yes 2	Pro 3 □ Pr	obably 4 🗀 Unknown
of Vital Records,	s been si should	Completed by	history or mas	tectomy e	for Brook	+00	2.7	1986		24a. Was		24b. Were au	itopsy findings available
Re	The lav ie has age 2	E		•				1 10 -		auto perfe 1 ☐ Yes	ormed?	death?	completion of cause of
ta	ding Phyaician: The I h. After this certificate ha funeral director, page		25. Was case referred to medical	ancer	in 197	6		26. Place	of Death	(Check only		0 10163	2140
>	Phyaician: this certifica ral director, i	To Be	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	spital:	2 ER/Outpatier	nt 3[7] DO	A Othe					6 ☐Other (Spe	cifv)
ō	g Phy er thi	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Yea			Bc. Injury Work	at		8d. Describe			
Ö	ndin ath. r: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 16	ar) Injury	м		 /es 2 □1	No				
Division	Atte	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury -	At home, farm, st	reet, factory,	, office		2	8f. Location (ural Route Number,
ā	s afte	Certification:	4 nomicide	building, etc. (S	респу)					City of 10	WII, Stat	θ)	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physic	cien: To the best of my	y knowledge, deat	h occurred a	at the tim	e, date an	d place, a	and due to the	cause(s	s) and manner as	stated.
	he H in 24 ihe Fi plete	edical	(Check only 2 Medical Examina one)	and manner stated.	mination and/or in	ivestigation,	in my op	oinion, dea	tn occurre	o at the time,			
	To t To t	Σ	29b. Signature and title of certifier			29c.	. License	number			29d. Da	ate signed (Mont	h, Dey, Year)
			and monion	7		D	586	46			mo	irch	2005
	15		30. Name and address of person who com	pleted cause of death	(Item 23a) (Type,	Print)							
	4		Anna Monius 8800	pleted cause of death Control Registrar's S	er Boul	evaro)	Par	kvi!	lle, V	40	2123	, 4
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's S	Signature	2 M. 2				•			,
	Registi	rar	MAR 0 3 2005	DE RIES	15. JED								

3/1/05 639

Coldwell, Magared

			For State Registrer		ryland / Dep		. Ensure All C Health and Mer Death	-	ne 200	5 0705
	Physici		1. Decedent's Name (First, Middle, Last)	Carberry				Date of Death	Day 2005	3. Time of Death 8:20 A M
	/Medio Examin		4a. Fecility Name (If not institution, give s 9323 Shady Creek				or Location of Death にmoれと		4c. County of Dee Balti	ith
*	Funeral Director		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthda 66 Yrs.		If I Inder 24 Hrs o	Date of Birth (Month, Day, Ye WICH 9, 1	0.00	nthplace (State or Foreign ountry) NYLAND
	•how	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	or 28a-i	Director	Delaware Sussex 10e. Street and Number 7 Dorothy Circle		/\	101. Zip Code	19970	10g.	Citizen of What C	
20	s lied within 72 hours after death with the Maryland I Hygiene. other than "natural", or items 23e or 28a-f ehow rent, tha Madical Examinar mast be notified at	by Funeral		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:	ver in U.S. 13	B. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Specify an, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Am Black, Whi	
215-0036	In /2 hour n "natural ladical Es	Completed b	15. Decedent's Educ (Specify only highest grade	cation completed)	(Giv	redent's Usual Occur re kind of work done DO NOT use retire	during most of working	168	b. Kind of Business	
N	Hygi Hygi other	Be Com	Elementary/Secondary (0-12) 12th Grade 17. Father's Name (First, Middle, Last)	College (1-4or 54	•) (Clerk	18. Mother's Name (F		lestern E	lectric
Z	d 2 should be th and Mental th and Mental ? is marked of traumetic eve	ToE	Sherman E. Mwr. 19a. Informant's Name/Relationship (Ty)		19b. Ma	iling Address (Stree	Lucy K.		ity or Town, State,	Zip Code)
Ž	0 5 b 5		Mr. Kevin Carberry 20a. Method of Disposition	y (son)		23 Shady (position (Name of ematory or other pla	Creek Way, I		e, MD 21	
baitimore,	it. Pa ritmen ritant: njury		1 ☐ Burial 2 【X Cremation 3 ☐ R *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature el, Funeral Service License		Bayview	Crematori		05 Ba	ltimore,	Maryland
n	Depa Impo any i	L	V/am			9705 Beli	iir Rd., Bai	timore,	MD 2123	6
	hysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	AMYU	o. 0100515 consequence of):)	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
9/60,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):	YELOMA				TWO YEARS
O. BOX 68	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	2 ☐ Fetal déath 3	B⊟Ectopic pregnanc ☐ Other (specify) _	у		23d. Date of de Month	Nivery Day Year
rds, P	w requires that the de been signed by the a should be detached t	b	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the	underlying cause gr	ven in Part I.	23e. Did tobac	N /	o the cause of death?
		Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
VITA	Physician; Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes No	lospital: 1 ☐ Inpatier	nt 2□ER/Outpati	ent 3 DOA	26. Place of Death (C		a V 10# (0-	Son' 4
DIVISION OF	fte.	 -	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day)	28b. Time	of 28c. inju	The second secon	I. Describe how		ocityk eswience
DIVIS	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, . (Specify)	street, factory, office	28f.	Location (Stree City or Town, S		lural Route Number,
	the Hospi iin 24 hou the Funer ipletely fill	edical	(Check only 2 Medical Examination one)	sician: To the best oner: On the basis of and manner state	examination and/or	investigation, in my	me, date and place, and opinion, death occurred a	at the time, date	and place, and du	e to the cause(s)
	To To Con	Σ	29b. Signature and title of cartifier	IMD.		29c. Licen			Date signed (Mon	*
	5		30. Name and address of person who call the two	0 1650	ORLOANS	e, Print) STREET,	28) Suite 209	Soun	ioro, Ma	Mr. 21531
	Sta	ate	31. Date liled (Month, Day, Year)		r's Signature	have.				

DHMH 17 Rev 1/2001

	1 - For State Registrar	State of Maryland	/ Department of Hea	•	rgiene Reg. No. 21115	07061
Physician /Medical Examiner	1. Decedent's Name (First, Middle, to CNCVV) 4a. Facility Name (If not institution, g	CVOWELL ive street and number)	4b. City, Town, or Lo	2. Date of De Month 3	Day Year 4c. County of Death	3. Time of Death 7
Funeral Director		Sex 7. Age (In yrs. las		f Under 24 Hrs. 8. Date of Bi Hours Min. (Month, Do		place (State or Foreign ntry) NC
death with the Maryland ms 23a or 28a-1 ehow funts to myllfied at neral Director	10a. State 10b. County M D N A 10e. Street and Number		Town or Location timore 10f. Zip Code		10g. Citizen of What Cou	10d. Inside City Limits 1 □XYes 2 □ No ntry?
and A 1 A 13-0030 be filed within 72 hours after death with the Marylan hal Hygiane. ed other than 'natural', or items 23a or 28a-1 ehow event, the Medical Examinational banalified at Be Completed by Funeral Director	1 West Conway 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 3 No If Yes, Give Year or Dates:	13. Was Decedent of Hispa If Yes, specify Cuban, I	O1 anic Origin? (Specify Yes or Not Mexican, Puerto Rican, etc.) Specify:	Specific	
be filed within 72 hours after that Hygiane. Id other than -natural; or its event, the Medical Examina Be Completed by Fu	15. Decedent's (Specify only highest s Elementary/Secondary (0-12) Unknown	College (1-4or 5+) NA	16a. Decedent's Usual Occupatio (Give kind of work done duri- life. DO NOT use retired) Factory Wor	ker	16b. Kind of Business/In	dustry
Maryiania A.1.Z. nd 2 should be filed within and Mental Hygiane. 27 is marked other than retaumatic event, the Mr. To Be Comp	17. Father's Name (First, Middle, La. George Long 19a. Informant's Name/Relationship	(Type, Print)	A 19b. Mailing Address (Street and		Cee er, City or Town, State, Zip	o Code)
ILIMOTE, I. Pages 1 at riment of Heart Hitem riant: If them njury or other.	Cindy Crowell 20a. Method of Disposition 1 Reurial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State 20b. Place certify) Kinc	3316 Edmonds of Disposition (Name of netery, creatory or other place) g Memorial Pa 22. Name and Address of March F/H	rk 3/7/05	Pandallsto	
Physician /Medical Examiner	23a. Part . Enter the titlease, or co sho x, or heart fail re. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death. y one cause on each line. a. SCSSS Due to (or as a consequence)	4300 Wabas Do not enter the mode of dying, s	h Ave, Balti		21215 Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter funding to Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequent c. Due to (or as a consequent d.				
death certifi ed for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopic pregnancy	(H574F47)	23d. Date of delive	ery Day Year
The law requires that the law requires that the page 2 should be detach	Part II. Other significant conditions	contributing to death but not resulting to the faulth	ng in the underlying cause given in	n Part I. 23e. Did t		he cause of death? bably 4 □Unknown psy findings available
	25. Was case referred to medical examiner?	Hospital:	Othor	autor period 1 ☐ Yes 3. Place of Death (Check only of	osy prior to condeath? 2 No 1 Yes	mpletion of cause of
ng P fter t nara	1 Yes 2 No 27. Manner of Death 1 Datural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury at Work? M 1 ☐ Yes	2 □No	dence 6 □Other (Specify how injury occurred Street and Number or Rura	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification; To Be C	4 Homicide determine 29a. Certifier (Check only one) 2 Medical Extended	hysician: To the best of my knowle miner: On the basis of examination and manner stated.	edge, death occurred at the time, o	City or Ton	vn, State)	tated
	29b. Signature and title of certifier August 29b. Signature and title of certifier 30. Name and address of person who	flereng	29c. License nu	niversity	29d. Date signed (Month.	Day, Year)
State Registrar	And Softia 31. Date filed (Month, Day, Year)		8	niversity	of Mary	land

crn			1 - State Unpend Item 2 RegistrarAmend Item 2	State of Marylan 3a,27,28a-f I 3pt.II per me	id/Departme Der me G842 G84 <i>2ertifica</i>	ent of Health and 2 4-8-05 tas ate of Death6-2	Mental Hyg 1-05 tase	piene 005	07055
	٥.		1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
	Physici /Medic		RONALD	DAVID	CARTE	ER	Februar	y 27, 2005	6:07 P ^M
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. Cit	ty, Town, or Location of Dea	th	4c. County of Death	
2			University of Maryl			Baltimore		N/A	
513	Funeral Director		5. Social Security Number 6. Security Number 15 15 15 15 15 15 15 15 15 15 15 15 15	7. Age (In yrs.	Ast birthday) If Und Month	der 1 Year If Under 24 Hr. as Days Hours Mir		9. Birth Cou	place (State or Foreign Intry) ARYLAND
	land ow		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	ours after death with the Maryland rat', or Items 23a or 28a-f show Exant mermust be rodified at	ctor	MARYLAND NI	IA		BALTIM	ORE (217/	1 Yes 2 No
	or 28	Funeral Director	10e. Street and Number		10f. Z	Zip Code	00	0g. Citizen of What Cou	ntry?
	ath w	rai	22/3 HS.	HTON STR	RET	2/2	23	USA	
		nne		12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was Dec	cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White,	can Indian, etc.
Maryland 21215-0036	hours after tural", or Ite	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ØNo If Yes, Give Year or Dates:	1 ☐ Yes	No Specify:		Specify:	ACIC
9-0	즉 표 등	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Decedent's Us	sual Occupation work done during most of wo	addin a	16b. Kind of Business/Ir	idustry
21	- A 35	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)	orking	3 4	
21	e filed within al Hygiene. I other than ' vent, I'e Me	Co	12 HTGRADE		LA	BORER			PROVEMENT
and	s 1 and 2 should be filed withi f Health and Mental Hygiene. Itam 27 Is markad other thar othar traumatic event, Itam	Be	17. Father's Name (First, Middle, Last)	N A 3/ / A	O O O TT		ime (First, Middle, i	Maiden Sumame)	
Ĕ	2 should be a nand Mental I is marked o raumatic eve	오	WINDSOR 19a. Informant's Name/Relationship (Ty		CARTE,	ess (Street and Number or F	VIH	DK.	OWN
∑	id 2 s lth an 27 ls i		FOITH CARTER		2213	/		TO, MD - c	
	s 1 and 2 if Health itam 27 l		20a. Method of Disposition	20b. P	Place of Disposition (N	Varne of		20c. Location - City or T	
OE	Pages nent of int: If it iry or o		Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	remetery, crematory of		-17-05	LANSDOW	15- 110
Baltimore,	artm orta inju		21. Signature of Funeral Service License	98 /)		and Address of Facility			ERAL HOME
ä	permi Depa Impo any ir		Latich	1 Willian	no 398	38 N. FUL		E. BALTO,	
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death	h. Do not enter the me	node of dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cardiac Arry	ythmia Duri	ing An Alterc	ation		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq					
		7.	Sequentially list conditions,	Due to (or as a conseq	uence off-				
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq.	derice or).				
<u>,</u>	be executed ician and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
8760	cate be e ohysician the buria	dical		1					
	tificate ng phys as the	ledi							
Вох	leath certific attending p	an/N	ZSD. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		pregnancy		23d. Date of delive	
. E	requires that the death certific een signed by the attending p hould be detached for use as	Physiclan/Me	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	4☐ Pregnant at time of de 9☐ Unknown				Month	Day Year
P.0	res that the de signed by the be detached		9 Unknown	atributing to death but not rec	ulting in the underbine	Death	230 Did tol		ha assume of death?
ds,	signe	d by	Cocaine And Herion Cocaine And Herion	n Intoxication	n, Asthma	g cause given in Part I.		pacco use contribute to t es 2 □ No 3 □ Prot	
Ö		etec							
Vital Records,	e la has je 2	Completed					24a. Was a autops perforr	v prior to co	ppsy findings available mpletion of cause of
<u>m</u>		မ င	25. Was case referred to medical			00 81		2□No 1□Yes	2 No
<u> </u>		To B	eyaminer?	lospital: 1 Inpatient 2	ER/Outpatient 3 ☐ [Other	ath <i>(Check only</i> on Home 5 □ Reside	e) ence 6 □Other (Specif	5(1)
Division of	iding Phys th. After this funeral di		27. Manner of Death	28a. Date of Injury Found Found	28b. Time of	28c. Injury at Work?	1	w injury occurred	unk
.0	Attending r death. sctor: After by the funer	atic	1 Natural 5 Pending investigation		Found P ^M	1 Yes 2 No			
Ξ̈́	or Att ifter de Direct in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specin	ome, farm, street, factory)	ory, office	City or Town	reet and Number or Rural, State) 1803 Sex	Route Number,
	ospital or Atten hours after deat uneral Director: by filled in by the			Scene			partimon	e, ma	
	Hos Fur tely	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigation	ed at the time, date and plac on, in my opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner as s ate and place, and due to	tated, the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1	2	9c. License number	2	9d. Date signed (Month,	Day, Year)
	W No		Inout & reis	thall ms		OCME		February 28	2005
10	Darry		30. Name and address of person who co	ompleted cause of death (Item	1 23a) (Type, Print) 1	11 Penn Stree			
	1		tamela E. Sol	thall, MD		TT LEINI PUTGE	- Dallin	ore, maryiai	10 41401
•	Sta Registr		31. Date filed (Month, Day, Year) WAR 03 20	32. Registrar's Signa	iture				

Physician Monte Long Courts Monte	
Markett Caralta	of Death 3. Time of Death
Medical Mary Lee Corke Marc	
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
Greater Baltimore Medical Center Towson	Baltimore
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date (Months Days Hours Min. (Months Days Hours Months Days Hours Min. (Months Days Months Months Days Months Months Days Months Mont	of Birth (th, Day, Year) 9. Birthplace (State or Foreign Country)
Director 216-20-8529 10 79 Yrs. Sept	. 14, 1925 Maryland
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland Baltimore Towson	1 ☐Yes 2 ☐ No
10a. State 10b. County 10c. City, Town or Location Towson	10g. Citizen of What Country?
400 Georgia Court 21204	U.S.A.
The second secon	
Armed Forces? I Never Married 2 Married I Never Married 2 Married I Yes, Sive I Yes, Specify Cuban, Mexican, Puèrio Rican, etc. I Yes, Sive I Yes, Sive I Yes, Sive I Yes, Sive I Yes 2 No Specify:	
See 2	Specify: White
To the first of th	16b. Kind of Business/Industry
College (1-4or 5+)	0
To be the first, Middle, Last) 12 1 Homemaker 18. Mother's Name (First, Middle, Last)	Own Home
The state of the s	Clarke
Tr. Father's Name (First, Middle, Last) Howard Ludwig Pearl 19a. Informant's Name/Relationship (Type, Print) Mr. Bruce H. Corke – son 18. Mother's Name (First, Middle, Last) Pearl 19b. Mailing Address (Street and Number or Rural Route Name) 810 Shirley Parkway Pisc	
2 de sa de s	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
O E S S S S S S S S S S S S S S S S S S	Baltimore, MD
20a. Method of Disposition Second Comparison Compa	ore, Maryland 21214
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or heart failure. List only one cause on each line.	ory arrest, Approximate Interval Between
Physician /Medical Examiner Indicate Cause (Final disease or condition resulting in death) Indicate Examiner Indicate Examiner Indicate Cause (Final disease or condition resulting in death) Indicate Examiner Indicate	Onset and Death
FFEMALE: 23b. Was decedent pregnant in the past 12 gonths? 1 Yes 2 No 9 Unknown 1 Notes 1	23d. Date of delivery Month Day Year
in the past 12 poinths? Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9 Unknown 2 Pregnant at time of death 5 Other (specify) 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Percent of the underlying cause given in Part I. 23e. Percent of the underlying cause given in Part I.	Did tobacco use contribute to the cause of death?
Fungenia gas seen sign as the reduction of the reduction	1 Yes 2 No 3 Probably Unknown
Premote the state of the state	Was an autopsy performed? fes 2 ▼ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
5 E S 25. Was case referred to medical 26. Place of Death (Check of Death (Che	
examiner? 1 Yes 2 No	Residence 6 □Other (Specify)
28d. Description of Death 28d. Description of 128c. Injury at 28d. Description of 128d. Description of 12	cribe how injury occurred
investigation M 1 Yes 2 No	
28d. Description of the property of the proper	tion (Street and Number or Rural Route Number, or Town, State)
The first of the f	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)
29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	2-1-05
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael L. Church GTG9V. Church St	1 601 Towsum.MI)
State 31. Date filed (Month, Day, Year) 32. registrar's Signature	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otato or ivi	arytanu / i	Certificate of		wichtai i iy	Reg. No.	05	07057
			1. Decedent's Name (First, Middle, L	ast)		0.31		2. Dete of De Month		لدك	3. Time of Death
1	Physici /Medi		Etta	L -		Colbert		2	24 2	Year 005	12:50pm
	Examir	ner	4a Fecility Name (If not institution, g Future Care N				4b. City, Town, or Baltin			y of Death NA	
	Funeral Director		5. Social Security Number 6. 231–58–1109 Usuel Residence of Decedent	Sex 1□ M 2(X)F 7. Ag	e (In yrs. last bii 2	rthdey) If Under 1 Year Months Days			rth ay, <i>Year)</i> -32	9. Birthp Coun	place (State or Foreign stry) Va -
	lend		10a. State 10b. County		10c. City, Tow	n or Location				1	0d. Inside City Limits
	Many Many	ţ	Md. NA		E	Baltimore					1X Yes 2 □ No
	or 28	Z e	10e. Street end Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
	ath w	rai	1244 E. North			2120				SA	
21215-0020	within 72 hours after death with the Marylend ene. than "nature!, or items 23a or 28e-f show he Medical Examiner must be notified at	Completed by Funeral Director	11. Maritel Status 1 ☆ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🐼 I If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub		specify Yes or No to Rican, etc.)	5- 14. Rad Bla Specif	ce - Americ ck, White, y: B	
5-0	natul	etec	15. Decedent's E (Specify only highest g	ducation rede completed)	16a	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of wo	rking	16b. Kind of B	usiness/Ind	Justry
121	within	dm	Elementary/Secondary (0-12)	College (1-4or 5	+)		d)		0'1		
9	Hygid Hygid Other		10th grade 17. Father's Neme (First, Middle, Las	1)	-	Bus Driver	18. Mother's Nar	ne (First, Middle	City W		us Co.
Maryland	ies 1 end 2 should be filed within i of Heatih and Mental Hygiene. I fitem 27 is marked other than "r other traumatic event, the Med	To Be	Aaron		Colbert	t	Mattie		Wi.	lliam	s
lary	and N		19a. Informent's Name/Relationship	(Type, Print)	19b	o. Mailing Address (Street					Code)
≥, ₹	end in m 27 in her tr		Mattie Harvey	Niece		100 Willow	Spring I				21202
Baltimore,	Peg nent int: I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	(b)	cemete	of Disposition (Name of try, crematory or other pta t. Carmel Ce	em.	Date 3-5-05	20c. Location Dunda	,	
Bal	permit. Depertr imports any inje		21. Signature of Funeral Service Lica	nsee wan	2	22. Name and Addre	-		altimore Ol E. No		
			23a. Pert1. Enter the diseese, or cor shock, or heart failure. List only	pplications that caused one cause on each lin	the death. Do	not enter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	1	Approximate Interval Between
	Physician /Medical Examiner	er	Immediate Ceuse (Final disease or condition resulting in death)			COV ARWU	CANCE	2			Onset and Death
lóx 68760,	death certificete be executed attending physicien end ed for use es the bunel-trensit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c		consequence of):					
P.O. Bóx	e deal	sici	Part II. Other significent conditions	contributing to death bu	it not resulting in	n the underlying ceuse giv	ven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
	res that the de signed by the a I be deteched f		Humotonsin					10	Yes 2□ No	3 Prob	ably 40 Unknown
ds,	uires t signe Id be	d by						24a Was	an autopsy	24b. We	re autopsy findings
of Vital Records,	law requires that the as been signed by th 2 should be deteche	Completed	Anenia						rmed?	ava	illable prior to npletion of cause leath?
m m	0 - 0	E						401	Yes 2 X No		Yes 2□ No
/ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	one)		
of \	Physician: this certific ral director,	유	1 ☐ Yes 2 No		nt 2 ER/Ou		Nursing n		dence 6 □Oth)
00	After funer	ţ	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injur (Month, Dey	Year) 28b. 1	Firme of 28c. tnjur njury Wor M 1 □	nyet rk? Yes 2 ∐ No	28d. Describe I	how injury occur	red	
Division	il or Attending i efter death. I Director: After d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	6 One Place of Init		rm, street, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural	Route Number,
	To the Hospital within 24 hours e To the Funerai I completely filled	Natural							cause(s) and ma date and place,	inner as sta and due to	ited. the cause(s)
	within 2 To the comple	Σ	29b. Signature end title of certifier			29c. Licens	e number		29d. Date signe		Pey, Year)
	MD D0059056 2/24							05			
	Į.		011-00-1	ALUJA MO	16	(Type, Print)	17 Royal 1	AVE B	Alt MC) 21.	217
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registre	r's Signeture	Socie					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:00 AM 23, 200s ALBALA CRAWFORD EGIVAT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Medical BALTMORE
If Under 1 Year If Under 24 Hrs. Center University of Mary land 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours .8371 1 M 2 F Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f show other traumatic event, the Madical Examiner must be notified at ANNE ARUNDET PASADEMA 1 ☐ Yes 2 ☑ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 Married Specify: L Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ JhITE 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "natural; eny injury or other traumatic event, the Medical Exa Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NGT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAWFORD, HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 4,MD. 21122 Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State 5 Other (Specify) 4 Donation Service Licens 21. Signatur 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part. Enter the disease, or complicate or heart failure. List only one Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): use as the burial-Division of Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atter edetached for u in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an page rmed? 2 □ No this certificate 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ² 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 28c. Injury at Work? 28b. Time of Certification: 27. Manner of Death 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier roman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2+ South Green St BACTIMUM Thomas 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature State 03 2005 Registrar

Logan Courtillet amend item//1, perfix: C841, 3/14/05 II Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene State amend item//17,18,19a,perInf, C841,3/18/05 TT Registrar 05-01554 2. Date of Death 1. Decedent's Name (First Middle, Last)
Logan Selby Courtillet
Logan Courtil Day Month **Physician** 2005 March 1 11:18 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Charles County Detention Center LaPlata Charles If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 22, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1√M 2□F Hours Months 20 213 15 6849 Clinton. Director 1985 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Itams 23a or 28a-f show rer roughbe notified at 1 ☐ Yes 2 ☐ No XX Maryland Prince George's Cheltenham Direct 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number P.O. Box 177 20623 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? other traumatic event, the Medical Examination filed within 72 hours after 1 ☐ Yes 2√VNo If Yes, Give Year or Dates: X1X Never Married 2 Married 3altimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental and Mental Marcel Courtillet Colin Courtillet Linda Ann Selhy Selby Courtillet (Parents) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
Linda & marcel Courti el Courtillet P.O. Box 177, Cheltenham, Maryland 20623 Health Item 27 20a. Method of Disposition
1 □ Burial 2 🛣 remation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō Department of Important: If any injury or one Lee Crematory March 8, 2005 Clinton, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 01d 21. Signature of Funeral Service Licensee MOD 153 Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 10 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and the sequential sequences of the sequence Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760. physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2KNo 3 Probably 4 Unknown 1 Tyes been signated Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed 2□ No 2 ☐ No Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 🗌 Nursing Home 5 ☐ Residence 6 ☐ Ather (Specify) SCENE 2 Yes 2 □ No this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 100 death. 1 TYes 2 Accident Director: 6 ☐ Could not be 3 Suicide lac 28f. Location (Street and Num City or Toym, State) er or Rural Route Number of Injury -At home, farm, street, factory, office determined 4 Homicide building, et 20646 6905 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at stated.

X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. S 2 March 2, 2005 OCME d cause of death (tem 23a) (Type, Print) M 111 Penn Street Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

			For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artment of H ertificate of I	lealth and M D <i>eath</i>		ene2 () ()	5 07060
			Decedent's Name (First, Middle, L.	_ast)	J			2. Date of Death Month	Day Y	3. Time of Death
	Physici /Medio		PAULINE F. C	ULLEN				MARCH	Day 21, 201	25 12:45P M
	Examir		4a. Facility Name (If not institution, g Saint Joseph	rive street and number) Medical Ce	enter	4b. City, Town, or	Location of Death	3	4c. County of Ba	Death ltimore
	Funeral				In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear)	Birthplace (State or Foreign Country)
L	Director		407-01-5637	1□ M 2 F	87 Yrs.			2/28/1	. 8 K	CENTUCKY
	and		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits
	Mary Fied	ţo	MD N	/ A	BAL	TIMORE				1 ∰Yes 2 □ No
	th the	Director	10e. Street and Number	/ ==		10f. Zip Code		10	g. Citizen of Wh	at Country?
	23a c		6906 CONLEY			2122			USA	
0000	be filed within 72 hours after death with the Maryland lat Hyglene. Id other than "natural", or items 23a or 28a-1 show event, the Madical Experiment matural be modified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ★Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 Mo If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ■ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. WHITE
3	2 hours		15. Decedent's	Education	16a. Dec	edent's Usual Occup	ation	. 10	Sb. Kind of Busi	
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7	e filed wil al Hygien other th	Con	12	0	HO	MEMAKER	40.11.45 11.		HOME	
<u>a</u>	d tal	Be	17. Father's Name (First, Middle, La SAM THOMPSON	st)				e (First, Middle, Ma A RATLIF		
>	3 ≥ 2 2	Ţ	19a. Informant's Name/Relationship	(Type Print)	19b. Maii	ing Address (Street a				ate, Zip Code)
Z N	nd 2 shouth and and 27 is ma		MRS. CHARLENE			WINDY F				
ā,	f Hea item other		20a. Method of Disposition		20b. Place of Disp					ty or Town, State
aitimor	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5			NISLAUS	3/4/	05 B	ALTIMO	ORE, MD.
Dail	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service	ansage .		ACZORÓWS 201 DUNE	SKI FUNE DALK AVE			
	100		23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused the	e death. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory arres	it,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	aSEPSIS						Onset and Death
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	nted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(,					
2	exection and and rial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a	consequence of):				,, , , , , , , , , , , , , , , , , , , ,	
00/0	cate be executed physician and the burial-transit	dicai		d						
P	artifica ing ph e as th	0	IF FEMALE:							
O. BOX	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} = 2 \subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	
Ľ	requires that the een signed by th hould be detache		Part II. Other significant conditions	s contributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contrib	ute to the cause of death?
corus	quires an sign uld be	ed by						1 🗌 Yes	2 No 3	☐ Probably 4 ☐ Unknown
0000	S 5	ompieted						24a. Was an autopsy performe	prid agl? dea	re autopsy findings available or to completion of cause of ath?
VIIGI	in: The l	e Co	25. Was case referred to medical				26 Place of Deat	1 ☐ Yes 2 h (Check only one)	No 1L	Yes No
	> 00	0 8	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Oth	O.C.	me 5 Residen	ce 6 Other	(Specify)
5	ng Phys fter this neral di	on; T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time Injury	of 28c. Injury Work	y at k?	28d. Describe how	injury occurred	
N S O	Attending ir death. ector: After by the fune	catio	2 Accident investigat 3 Suicide 6 Could not	t be			Yes 2 □No	206 Lacation (Stre	at and Alumbas	or Dumi Doute Alumbor
<u>></u>	after of Direction by	Certification;	4 Homicide determine	building, etc.		treet, factory, office		City or Town,		or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of earn manner state	xamination and/or i	th occurred at the tin	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and mann e and place, and	er as stated. d due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of contifier	/1		29c. Licens	e number	290	d. Date signed (Month, Day, Year)
			1	row	an	D 37	254		3/2/	25
	10		30. Name and address of person wh		th (Item 23a) (Type				1	
	Sta		31. Date filed (Month, Day, Year)	327Registrar	OSLER I s Signature	RIVE TO	WSÖN, MA	ARYLAND	21204	
	Regist	rar	MAR 0 3 20	JUS ADDRESS	S. A.	sale!				

				State of Maryland / Department State Registrer State of Maryland / Department Certificate	nt of Health and Me te of Death	lental Hygien	2000	07061
				Decedent's Name (First, Middle, Last)		2. Date of Death	ay Year	3. Time of Death
		Physicia /Medic		Franklin Thornton Co	lvin		23, 2005	4:50 P ^M
		Examin		4a. Facility Name (If not institution, give street and number) 4b. City.	Town, or Location of Death	4	c. County of Death	
				Stella Maris Hospice Ctr.	TOWSON	8. Date of Birth	Baltimore	
		Funeral		Months		(Month, Day, Yea		lace (State or Foreign
_		Director		223-40-8290 71 Usual Residence of Decedent		NOV. 3, I		irginia
à		ryland		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ Xio
0		72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show Jicul Examiner must be notified at	by Funeral Director	Maryland Baltimore	Dundalk	140-	Distance of Mills on Course	
S		with th	Dire	10e. Street and Number 10f. Zig			Citizen of What Cour	•
#		eath w	eral	1609 Gray Haven Court Court 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S.	21222		nited Sta	
	"	after dea or Itams	Fun	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
3	036	al', ol	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: Korean 1 ☐ Yes	2 CXNo Specify:		Specify: W	hite
25,2005	21215-0036	72 hours "natural",	Completed	15. Decedent's Education 16a. Decedent's Usu (Specify only highest grade completed) (Give kind of wo	ork done during most of worki	ing 16b.	Kind of Business/In	dustry
6	121	within lene. than "	mpl	Elementary/Secondary (0-12) College (1-4or 5+)			1 - 3	
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1	au	id be ental ked o	To Be	David Colvin		Racha	el Griffi:	n
41	Maryland	12 should be filed within h and Mental Hygiene. 7 is marked othar than " fraumatic avant, the Max	-		s (Street and Number or Rura	al Route Number, City	y or Town, State, Zip	Code)
\$		ss 1 and 2 should be filed within 72 hours after death with the Maryls of Health and Mental Hygiene. itam 27 Is marked othar than "natural", or Itams 23a or 28a-1 shor rothar traumatic avant, the Modical Examiner must be notified at			ay Haven Ct.			
PEBRUMA!	altimore,	of He of He II itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	me of ther place)	Date 20c.	Location - City or To	own, State
8	Ĕ	permit. Pages 1 Department of H Important: If ita any injury or ot once.		4 □Donation 5 □Other (Specify) Meadowridge M			Dorsey, M	
14	Ball	Depart Depart Import any in			nd Address of Facility Ruck Funeral			
		402.00	-	29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mo	Wise Ave. Du	ndalk Mar or respiratory arrest,	yland 21	222 Approximate
				shock, or heart failure. List only one cause on each line.	, 3 .			Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. LiveA CARCER Due to (or as a consequence of):				
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	60,	ate be executed nysician and he burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
	Box 68760	icate t physics the b	dicai	d				
	×6	eath certific attending pl	/Me	FFEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	əry
		death a atter d for u	iciar	in the past 12 months? 4 Pregnant at time of death 5 Other (s			Month	Day Year
2	P.0.	that the de ed by the detached	Physician/Med	9 ☐ Unknown				
うつる		se un es	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		o use contribute to t	
4	Records,	w require been si should b				1 Tes		
ď	ec	e law r has be je 2 sh	Completed			24a. Was an autopsy	24b. Were auto	ppsy findings available impletion of cause of
O			Con			performed	No 1 ☐ Yes	2 No
7	Vital	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	Other	h <i>(Check only one)</i> ome 5 ☐ Residence	Charles (Casa)	Mas Oue G
3	of	Phys r this ral dii	- To	1 Yes 2 No 1 Inpatient 2 Envoutpatient 3 D	OA 4 Nuising no	28d. Describe how in		Hospice
マ	lon	nding f ith. :: After s funer	Certification:	1 Watural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M	Work? 1 □ Yes 2 □ No			
Z	Division	r Attandi er death. ractor: A by the fu	ifice	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	ry, office	28f. Location (Street City or Town, St.	and Number or Run ate)	al Route Number,
RANKL	Ö	spital or ours afte naral Dir filled in	Cert	January, January,				
,4		To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifics completely filled in by the funeral director, i	edicai	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation	dat the time, date and place, n, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as s and place, and due t	stated. o the cause(s)
4		To the Hos within 24 h To the Fun completely	Med	one) and manner stated. 29b. Signature and title of certifie) 29	9c. License number	29d. l	Date signed (Month,	Day, Year)
		T wii		12_	D4272 -		2/25/05	
		141		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	11127			
		10,		DR. TARIA MAHMOOD 2300 DULA	JEY VALLEY R	D. TIMONIL	M, MD.	21093
		Sta		31. DAMAR (Month Daz 1955)				
		Regist	rar					

DHMH 17 Rev 1/200

FEBRUARY

CPM 05-01501 Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene. David Campofreda 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27, **Physician** David Bruce Campofreda February 2005 10:19 A^M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale Baltimore Months Days Hours Min. February 8, 1950 5. Social Security Number 6. Sex 10 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) Maryland 220-54-7223 55 Director Yrs. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is markad othar than "natural", or itams 23a or 28a-f shov traumatic avant, it a Mudical Examinar must be notified at Maryland Baltimore Baltimore Funeral Director 1 ☐ Yes 2 👿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9202 Swiven Place 21237 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) salesman 10 automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental F Nicholas William Campofreda Ellen Teresa McCourt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Danielle Hill/daughter 119 N. Union St. 19977 Smyrna, DE othar 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: ff any injury or once. `4 Donation 5 DOther (Specify) Most Holy Redeemer Cem.Mar. 4,2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee Mitchell Wiedereld Funeral Home, Inc 6500 York Rd. Baltimore, MD 21212 23a. Pm11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Hypertensvie atherosclerotic cardiovascular disease /Medical Examiner Sa uentially list and the first any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic obstructive pulmonary disease Completed 1 ☐ Yes 2 ☐ No 3 Probably **D**Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of page 2 certificate death? 2 🗆 No 2 🗆 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 1X Yes 2 No 2 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funaral C
completely filled the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME

State Registrar

31. Date filed (Month, Day, Year)

MAR 0 3 2005

30. Name and address of person who completed cause of beath (Item 23a) (Type, Print)



February 28, 2005

Baltimore, Maryland 21201

		State of Marylar Registrar	nd / Depa		Health and M	lental Hygid	•	25 0706
Physic /Med Exam	ical	1. Decedent's Name (First, Middle, Last) BONG RAE CHUNG 4a. Facility Name (If not institution, give street and number) HOWARD CONTY GENERAL III			or Location of Death	2. Date of Death Month	Day Yea 27 200 4c. County of Di	5 1.58 AM
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. 214-08-2567 1 M 2X) F 83	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,) JAN • 25,	(ear) 9.1	Birthplace (State or Foreign Country) Korea
th the Maryland or 28a-f show u notified at	Director	10a. State 10b. County 10c. Ci	ity. Town or Lo	10f. Zip Code		100	g. Citizen of What	10d. Inside City Limits 1 Yes No Country?
DESILITIOF E. INICITY INICITY IN A 17-13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modified Examination to inclined at mone.	by Funeral C	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced 12. Was Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		210 Was Decedent of H f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, Thite, etc. Asian
Baltimore, Maryland ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or any injury or other traumatic event, the Marietal Examples.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire nemaker	during most of work	ing 16	Own Hor	
ryiano, hould be filed d Mental Hyg marked other matticevent,	To Be C	17. Father's Name (First, Middle, Last) Byung Ki Kan 19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ng Address (Street	18. Mother's Name Unknown and Number or Rur.			a. Zip Code)
Ore, Ivial jes 1 and 2 si of Health and if item 27 is r		Jae Hoon Chung – son 20a. Method of Disposition 1 National 2 Occupation 3 Deemoval from State	8726 M Place of Dispos cemetery, cren	Manahan D sition (Name of natory or other plan	Orive, Ell	icott Cit		21043
Dallim permit. Pag Department Important: any injury o		14 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Ga:	dge Mem. Name and Addre ry L. Kai 50 Washir		/2005 eral Home	Elkridge @ Meadow	ridge MP, Inc. 21075
Pnysician /Medica Examiner			PTIC		ng, such as cardiac			Approximate Interval Between Onset and Death
te be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consect of the consect of	quence of):	(10 60	7 (8~) /			
hat the death certificated by the attending phy delached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Felt 4 ☐ Pregnant at time of 0 9 ☐ Unknown	al death 3	Ectopic pregnancy	у		23d. Date of o	delivery Day Year
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i: The law requir		PULLOWARY TUBERLING	513			24a. Was an autopsy performe 1 Yes 2	prior (ed/2 death	autopsy findings available to completion of cause of ? es 2/2 No
LIVISION ON VITAI DECOLOS, F.C. BOX 00 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined Coulding, etc. (Species	28b. Time of Injury	M 1 □	ner: 4 ☐ Nursing Ho ry at rk? Yes 2 ☐ No	28d. Describe how	ce 6 Other (S	pecify) Rural Route Number,
To the Hospital within 24 hours a To the Funeral i completely filled	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my kning physician (Check only one) Certifying Physician: To the best of my kning physician (Check only one)	owledge, death ation and/or inv	occurred at the tild vestigation, in my o	me, date and place, opinion, death occurr	and due to the cau red at the time, date	se(s) and manner e and place, and d	as stated. lue to the cause(s)
To t Withi To t	×	29b. Signature and title of certifier			569 48		d. Date signed (Mo	
B		30. Name and address of person who completed cause of death (Ite JAN) A 522 31. Date filed (Month, Day, Year) 37 Registrar's Sign	17-16	2Hyni ST	nest!	BALTINO	THE MD	4217
S Regis	tate	131. Date filed (Month, Day, Year)	B. Apr	we				

		1 - For State Registrar	State of Mary	land / Depa		Health and	Mental Hygi	ene g. No.2 0 0 5	0706
Physici /Medic		1. Decedent's Name (First, Middle, Last) Anna Mary Do					2. Date of Death	Day Year	
Examin		4a. Fecility Name (If not institution, give s 5414 Forge Road 5. Social Security Number 6. Sex		yrs. last birthday)	White	or Location of Dea Marsh Ir If Under 24 Hr	S R Date of Righ	4c. County of Dea Baltime 9. Bir	
Funeral Director		214-72-5180 Usual Residence of Decedent	1M 2DXF 92	Yrs.	Months Day	s Hours Mir	Month, Day, Aug. 21,	1912 Ma	ryland
Ba-f show	ctor	10a. State 10b. County Maryland Baltimo		c. City, Town or Lo	rite Mar				10d. Inside City Limits 1 ☐ Yes 2 💢 No
ath with the 23s or 21	Funeral Director	10e. Street and Number 5414 Forge Road			10f. Zip Code	21162		U.S.A.	
iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Easter are must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X N		Specify Yes or No- into Rican, etc.)	14. Race - Am Black, Whi	
within 72 ho ene. than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 11th Grade	cation a <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	ne during most of w red)	orking	6b. Kind of Business Own Ho	-
uld be filed Aental Hygie rked other tic event, t	To Be Co	17. Father's Name (First, Middle, Last) Charles Dannet	tal				ame (First, Middle, M		
and 2 shousalth and No. 27 is ma		19a. Informant's Name/Relationship (Ty Mrs. Nettie Fisher	. (daughter	i) 5414	Forge i	Road, Whi	te Marsh,		?
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Depa Impo eny ii		1/1/Ca	M.	9	705 Bec	air Rd.,	Baltimore	, MD 21236	
Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	tem Ce	re brou	1 ASU) Au	Accido	wt	Interval Between Onset and Death Z DAY
te be executed ysicien and te burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic pregnar □ Other (specify)			23d. Date of de Month	livery Day Year
quires that n signed b uld be deta	ρ	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	inderlying cause (given in Part I.	23e. Did tob 1 ☐ Ye	0	o the cause of death? robably 4 □Unknow
The law requir te has been si page 2 should	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of s 2 \(\text{No} \)
ician: certifica rector.	Be	25. Was case referred to medical examiner?	Hospital:	-5		Thor-	eath (Check only one	•	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time of Injury	of 28c. In	4 Nursing	28d. Describe ho	nce 6 ⊡Other (Spe w injury occurred	early)
tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S		reet, factory, offic	ce	28f. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
To the Hospital within 24 hours To the Funeral completely filled	edical		sicien: To the best of m ner: On the basis of exa and manner stated.						
To the within To the comp	Me	29b. Signature and title of certifier	gros u	0		o18758		d. Date signed (Mon	
6		Name and address of person who con the control of t	ompleted cause of death	(Item 23a) (Type 200, 49	Ly Coop L	ell Blod.	BARDHING,	MA 212	236
Sta		31. Date filed (Month, Day, Year) MAR 0 3 200	32 Registrar's	Signature	sells				

TOD 415am

DOD 3/1/05

Dobson, Anna Mary

			For Stete Registrer	State of Man		artment of F		= 17	670	n. Pros
			Decedent's Name (First, Middle, Las	t)				2. Date of Death	2. No.2	3 time of beath
ı	Physici /Medio		Marilyn	Κ.	Dur	n		February	28, 20	005 5:00 P M
	Examir		4a. Facility Name (If not institution, give			1	r Location of Death		4c. County of	Death
		E.	Morningside Assist 5. Social Security Number 6. Se		n yrs. last birthday		ville	O Date of Birth		timore
	Funeral Director			7. Age (//	79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1) Feb. 23,	1926	Pennsylvania Birthplace (State or Foreign Country) Pennsylvania
	D		Usual Residence of Decedent			1		1 CD. 20,	1320	Cilisyivania
	anylar show	2	10a. State 10b. County		0c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M	Director	Maryland Baltimor	<u>'e</u>	Towson	10f. Zip Code			Cities and Marie	
	3e or		1000 E. Joppa Ro	na d		21286	5	100	g. Citizen of Wh	•
	death	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.) Iispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		American Indian,
ထ္ထ	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	į	1 ☐ Yes 2 ☐ XNo	an, мехісап, Риепо Specify:	Hican, etc.)	Specify:	White, etc.
5-0036	hours turel',	d by	3 Widowed 4 XDivorced	Year or Dates:						White
5	be filed within 72 hours atter death with the Maryland ital Hygiene. d other then "neturel", or Items 23e or 28e-f show event. The Medical Exeminer must be notified at	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	b. Kind of Busi	ness/Industry
212	d with	lmo:	Elementary/Secondary (0-12)	College (1-4or 5+)	S	ecretary			Insuran	ce Company
p	ould be filed Mental Hygie arked other etic event, It	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma		oc oompany
Maryland		To	Lewis R. Kurtz				Hanna	Mayb		
Mar	12 sh h and 7 is m ireum		19a. Informant's Name/Relationship (T							ate, Zip Code) 21013
	s 1 and 2 should if Health and Mer item 27 is marke other treumetic		Lewis R. Kurtz, C		20b. Place of Dispo	sition (Name of				aldwin, Maryland ty or Town, State
Ē	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 3 ☐ I	Removal from State	_{сөтөtөгу, сго.} Bel Air M	matory or other place	3-5-2			
altimore,	permit. Pages Depertment of Importent: If it any injury or o		21. S mater of Fun al Se vice Licens						el Air	Maryland 1 Home, Inc.
m —	Per E		Taul Wage	in		1050 York	Road	Towson, M	aryland	21204
ii.			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	ications that caused the ne cause on each line.	death. Do not en	ter the mode of dyin				Approximate Interval Between
	Priysician	i n	Immediate Cause (Final disease or condition resulting in death)	a. REFRE	1CTORY	H490	DXEMIA	1		Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (or as a co						
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsequence of):	STRUC	TIVE PU	LMONA	ey DIS	EASE DERENDE
/	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	CIGAR	ETTE	USE.				deaden
oʻ	e exection and an and and and and and and and and		resulting in death) Last	Due to (or as a co	onsequence of):					
8/60	cate be executed physician and the burial-transit	dlcal		d						
×		/Mec	IF FEMALE:	23c. If yes, outcome of p	vrogo a nov					
X P P	death certiti e attending d tor use as	Physician/Me	in the past 12 months?	1 Live birth 2 □ 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,
o.	the d y the iched	nysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown						
ທົ	requires that een signed b	ру Р	Part II. Dther significent conditions co			nderlying cause give	en in Part I.	23e. Did tobac	co use contribu	ite to the cause of death?
ğ	v require	ted	SLEEP APNE	SYNDR	OME			1 Yes	2 □ No 3[□ Probably 4 □Unknown
Kecords	law as b	Completed	MORBID OBE	SITY				24a. Was an autopsy	prio	re autopsy findings available r to completion of cause of
	T afe bag			PARTIAL	OMPLE	X SEIZ	URES	performe		th? Yes 2□ No
VItal		o Be	25. Was case referred to medical examiner?	Hospital:	о (П ЕВ 10 · · · ·	Othe	26. Place of Death		· ·	hor ou E
Ö		-	27. Manner of leath	28a. Date of Injury	2 ER/Outpatier	28c, Injun	er: 4 □ Nursing Ho	me 5 ☐ Residence 28d. Describe how		Specify) HOSPICE
000		atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	oar) Injury	Worl M 1□	Yes 2 □ No			
UNISION	I or Atten after deat Director: I in by the	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	et and Number o	or Rural Route Number,
ב	pitel o	O	20.0.11				1			
	To the Hospitel or At within 24 hours after of To the Funerel Direc completely tilled in by	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exami	sician: To the best of m ner: On the basis of exa and manner stated.	amination and/or in	occurred at the time of the time of the time of the time occurred at the time occurr	ne, date and place, a pinion, death occurr	and due to the caus ed at the time, date	e(s) and manne and place, and	er as stated. due to the cause(s)
	To the within To the	Me	29b. Signature and title of gertifier			29c. License	number	29d.	Date signed (A	Month. Day, Year)
			Lois E. VI	elsen	MD	D3	8327		3/1/0	5
	in		30. Name and address of person who co	ampleted seven of double	(Item 23a) (Type.	Deies		0 4700	1 7000	Ca. A 210 022
	10		LOIS E NIEZSE 31. Date filed (Month, Day, Year)	N M D 32(Registrar's	Signature	>12K P/1	CIYKE D	K +206	1000	SON, MO 2604
	Sta Registra		MAR 0.3 200	5 September 5	A La	rolls				

			For State Registrar	State	of Marylan	d / Depa		t of H	lealth a	and M	ental Hy	gien		07067
	- I		Decedent's Name (First, Middle	, Last)				0		1	2. Date of De	_		3. Time of Death
	Physici /Medic		MARION ADAM								March '		005 Year	1:00AM M
	Examir	er	4a. Facility Name (If not institution Howard County	. •	-	1		Town, or ${\sf umb} {\sf i}$	Location o	of Death		40	County of Death HOWard	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th Voar		lace (State or Foreign
	Director		040-09-0092 Usual Residence of Decedent	1 □ M 2 XX	94	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da September	ŕ 18,	1910 Conne	ecticut
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show fre M. Jica. Examirar must be notified at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City Limits
	Ba-f s	Completed by Funeral Director	Maryland Balti	nore	Bal	timore								1 ☐ Yes 2 XXX
	with ti	Dire	10e. Street and Number 6425 Blenheim	Poad			10f. Zip	212	12			10g. Ci	itizen of What Cour	itry?
	death	nera	11. Marital Status	12. Was Dec	edent Ever in U	S. 13. \	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Americ	
36	or Ite	y Ful	1 Never Married 2 Marr	If Yes, G	2 X XNo ive		rYes, sp <i>ec</i> 1 ∐ Yes		n, Mexican Specify:	i, Puerto i	Rican, etc.)		Black, White,	etc. Nite
Ö	hours tural	ed b	3XXWidowed 4 □ Divorced 15. Decedent	Year or I	Dates:	16a. Deced						16b k	Kind of Business/Ind	
215	hin 72 an "na Madic	plet	(Specify only highes	t grade completed,) (1-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired	during mosi)	t of workir	ng	100. F	VIIId OI BUSINESSYNIC	ustry
2	ed wit ygiene nar the	Com	Elementary/Secondary (0-12)			Se	ecreta	ary					Sports (Club
land	should be filed within 72 hours after death with the Marylan and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show tumatic evant, the Marical Examinat must be notified at	To Be	17. Father's Name (First, Middle, Charles A.		dams				18. Mothe		(First, Middle,	Maider		ran
Baltimore, Maryland 21215-0036	is 1 and 2 should of Health and Men itam 27 is marka othar traumatic		19a. Informant's Name/Relations Marilyn E Demore	nip <i>(Type, Print)</i> 2st	Dtr	19b. Mailin 6425	Address Blent	(Street a	Road	or or Rura Bal	timore,	er, City Ma	or Town, State, Zip ryland 21	Code) 212
ore,	es 1 ar of Hea of Hea fitam rotha		20a. Method of Disposition XX Burial 2 □ Cremation	2 D D	20b. P	lace of Dispo emetery, cren	sition (Nam	ne of ther place	9)	D	ate	20c. L	ocation - City or To	wn, State
Ĕ	Pages tment of tant: If it: jury or o		*4 □ Donation 5 □ Other (S	pecify)	Beav	verdale 1	Memoria	al Pa	rk 3	/5/0			den, Conn	
Bal	permit. Pages Department of I Important: If its any injury or o		21 Signature of Funeral Service	sicenspe	rakes	22	. Name and	d Addres					feld Funeral ore, Marylar	
I,			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death	n. Do not ente	er the mode	of dying	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	9	Immediate Cause (Final disease or condition resulting in death)		therosc		: Carr	icv	ascul	ar D	isease			Onset and Death
	Examiner			i e	(or as a conseq	vence of):								
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Due to	(or as a conseq	uence of):								
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consequ	ience of):								
/60,	ate be executed hysician and the burial-transit	calE		Jus 10	(or as a consequ	1611C6 OI).								
9	death certificate e attending physical for use as the													
ROX	leath certific attending p I for use as	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	itcome of pregna birth 2 □Fetal	death 3	Ectopic pre						23d. Date of deliver	ry Day Year
	res that the designed by the a	Physiclan/Med	1 □ Yes 2 XXIVo 9 □ Unknown	4□Pregi 9□Unkn	nant at time of de nown	eath 5□	Other (spe	ecify)					WORK	Day Feat
1	requires that the een signed by th hould be detache	by Ph	Part II. Other significant condition	ns contributing to c	leath but not resu	Ilting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco	use contribute to the	e cause of death?
ecords,	w require been sig should b										1 🗆 Y	'es 2	□No 3□Proba	ably XXUnknown
ပ္တ	> - 70	ompleted									24a. Was autop	sy	prior to con	sy findings available appletion of cause of
E E	ician: The lav certificate has rector, page 2.	0	05.111								perfor	XX No	death?	2□ No
VItal	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes XXNo	Hospital: XX	Inpatient 2	ER/Outpatieni	3 000	Othe			(Check only o	-/	6 ☐Other (Specify	1
0 0		T:uc	27. Manner of Death 1XXVatural 5 Pending	28a. Date	of Injury	28b. Time of Injury		Sc. Injury Work			8d. Describe h			/
VISION	Attanding r death. actor: Afte by the fune	catlo	2 Accident investig	ation			М	1 🗆 Y	es 2□N					
<u>></u>	al or At after o I Dirac d in by	Certification:	4 Homicide determi	ned 28e. Place build	e of Injury - At ho ing, etc. (Specify	me, farm, stre	eet, factory,	office		2	Bf. Location (S City or Tow		nd Number or Rural 9)	Route Number,
	To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 2 Medical E	Examiner. On the D	e best of my kno- basis of examinal aner stated.	wledge, death ion and/or inv	occurred a restigation,	it the time	e, date and inion, deat	d place, ai h occurre	nd due to the d d at the time, d	ause(s)) and manner as sta d place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	and than	inor stated.		29c.	License			2	29d. Da	te signed (Month, D	Day, Year)
	-							D437	/25				3/1/05	
	/		30. Name and address of person v					D = 1	4 2		7	. 01	004	
	Sta	tę	Tariq Mahmood 2 31. Date filed (Month, Day, Year)	01–109 Ba	CK RIVE Registrar's Signa		KUad	Rg1.	LIMON	e, M	arylanc	1 21	221	
e e	Registr		MAR 03	2005	Aug.	C	S							

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

204

2005

	1 - For State Registrar		State of r	viaryland /		artment of i rtificate of	lealth and N Death	nental Hy	gieni Reg. No	2000	07069
cian	Decedent's Na	ne (First, Middle, Las	it)					2. Date of De	ath Da	ay Year	3. Time of Death
dical		Esther			Edwa			2	26	2005	10:10p M
iner		(If not institution, give	street and numbe	ər)			or Location of Death		40	County of Dea	
	5. Social Security	rist N.H.	ex 7.	Age (In yrs. last	hirthday)	Towso		8. Date of Bi	th	Baltimo	Dre hplace (State or Foreign
al or	246-38-	1	□M 2½□F	77	Yrs.	Months Days	Hours Min.	(Month, D. 5-10-	ay, Yea <i>r,</i>) Co	niplace (State of Poreign buntry) N.C.
	Usual Residence	of Decedent 10b. County		10c. City, To	our or Lo	nation					
5	Md.	NA				more					10d. Inside City Limits 1X Yes 2 □ No
Director	10e. Street and N	umber				10f. Zip Code			10a Ci	itizen of What Co	
D	1721	E. 25th St	reet			2121	.3		109. 01	USA	Mility:
Funeral	11. Marital Status		12. Was Deceder		13. \	Was Decedent of i	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No)-	14. Race - Ame	
y Fu		ried 2 Married	1 Tes M		1	i Tes, specify Cub 1 □ Yes 2 🛣 No		rican, etc.)		Black, Whit	
d by	3 Widowed	4 Divorced	Year or Dates							Specify: B]	.ack
Completed		15. Decedent's Ed	ucation de com <i>pleted)</i>	16	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16b. K	(ind of Business/	Industry
m o	8th grad	_	College (1-4d	or 5+)		sewife	۵,			wn Home	
Be C		(First, Middle, Last)			HOUL	CWILE	18. Mother's Nam	e (First, Middle			
To E	Shadi	rick]	Bassnett			Lucy		I	Fields	
		Name/Relationship (7					and Number or Run				Zip Code)
	Randolph Edwards Son 5757 Edge Park Rd., Baltimore, Md. 21. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City of										
To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Calvary Cem. 20c. Location - City or Town, State 3-4-05 Anne Arundel Co.,										
	_	5 Other (Specify uneral Service Licen								re, Md.	
N N	21. Signature of F	& lade	300			. Name and Addre				North Av	21202
	23a. Part1. Enter	the disease, or comp	lications that caus	ed the death. D						NOLCII AV	Approximate
1					O 1101 01111	or the mode or dyn	ig, such as cardiac	or respiratory a			
	Immediate Cause		A /A	line.	~		ng, such as cardiac	or respiratory a	.,,		Interval Between Onset and Death
1	Immediate Cause disease or condit resulting in death	(Final on	a. OVA	UPN as a consequence	Ĉ	1CU	ig, such as cardiac (or respiratory a			
r	disease or condit resulting in death	(Final on	a. OVA	LPN as a consequence	ce of):		ig, such as caldide t	or respiratory a			Onset and Death
r	disease or condit resulting in death	(Final on	a. OVA	UPN	ce of):		ig, such as caldiac (or respiratory a			Onset and Death
aminer	Sequentially list of any, leading to cause. Enter Unc	(Final on	a. Due to (or a	as a consequence	ce of):		ig, such as caldiac (or respiratory a			Onset and Death
Examiner	disease or condit resulting in death Sequentially list of if any, leading to cause. Enter Unc	(Final on	a. Due to (or a	LPN as a consequence	ce of):		ng, such as calulac (or respiratory a			Onset and Death
Examiner	Sequentially list of any, leading to cause. Enter Unc	(Final on	a. Due to (or a	As a consequence	ce of):		ig, such as caldiac (or respiratory a			Onset and Death
Examiner	disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause Unsease that initiated even resulting in death	(Final on on ditions, mmediate erlying r in jury is Last	a. Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcome	as a consequence as a consequence as a consequence as a consequence	the of):	CU		о гозупатогу а		23d. Date of deli	Onset and Death
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hysician/Medical Examiner	disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause Unsease that initiated even resulting in death. IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	(Final on	a. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or	as a consequence as a c	ce of): ee of): ee of):	Ectopic pregnance Other (specify)	,	л юзупатогу а			Onset and Death
by Physician/Medical Examiner	disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause Unsease that initiated even resulting in death. IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	(Final on onditions, mmediate erlying ris Last	a. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or	as a consequence as a c	ce of): ee of): ee of):	Ectopic pregnance Other (specify)	,	23e. Did t	pbacco u	Month use contribute to	very Day Year
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by Physician/Medical Examiner	disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause Unsease that initiated even resulting in death. IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	(Final on	a. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or	as a consequence as a c	ce of): ee of): ee of):	Ectopic pregnance Other (specify)	,	23e. Did t	obacco u (es 2	Month use contribute to No 3 Pro 24b. Were au	very Day Year
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humber.

> State Registrar

itle of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AALON OHAWES WY GOL N. CWA (CS)

31. Date filed (Month, Day, Year)

AR 2005

5+

29d. Date signed (Month, Day, Year)

27 2005

Baltimore NO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. item#24a, perverbal, G841, 3/3/05 TI State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28, Emmons February Willie 2005 7:00 a Tames /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Edgewood Baltimore Young at Heart Assisted Living If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-18-2909 1ĂM 2□F 80 1925 Director Jan. Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ahow ed other than "natural", or itams 23s or 28s-f show event, the Medical Exempres must be notified at 1 Yes 2 No Directo N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 114 S. Calhoun 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Automobile 6th Paint Repair 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Irene Mallory Adolphus William Emmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun Jerry Emmons/Son 66 Portship Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery Mar. 5, 2005 Baltimore, MD * 4 ☐ Donation , 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, MD 21229 23a. P. rt./. Enter the disease, or complications that chief the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on what line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 recontes **Physician** cordio m /Medical Due to (or as a consequence of): **Examiner** BACKE 3 years. squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 26 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide

To the Hospital within 24 hours a

> State Registrar

Medical

31. Date filed (Month, Day, Year) 03 2005

(Check only

29b. Signature and title of certifier

S. Renguerai,

32. Signature مستان الكالم

. Reegurag. no

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

602, C. Aturocal Rd. #106.

🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-53720

Belowir.

29d. Date signed (Month, Day, Year)

03 |01 2005

21014

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Consider Name Principle Content Conten				1 - For State Registrar	State of M	larylan		artment rtificate			ınd M		Reg. No.	200	5 07071
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ORIGINAL

				1- For State of Maryland / Department of Health and N Registrer Certificate of Death	Mental Hygier	21115 07072
				1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	3. Time of Death
		Physici /Medio		Esther Mae Fleishman		24. 2005 15:25 M
		Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
				700 West Bel Air Avenue Apt 214 Aberdeen		Harford
		Funeral Director		5. Social Security Number 6. Sex 1 M 2 K F 7. Age (In yrs. last birthday) 90 Yrs. 1 Vrs. 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year Feb. 12,	1915 Sirthplace (State or Foreign Country) Maryland
		and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
		Marylan f show	ō	Manual and Manual and Manual and		1 ŽXYes 2 ☐ No
		288.	Director	Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code	10a. (Citizen of What Country?
5		23a or		700 West Bel Air Avenue Apt 214 21001		SA
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ي ــــ	9	after dea or items miner m	Ē	1 Never Married 2 Married 1 Yes 2X No	Rican, etc.)	Black, White, etc.
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- leishman	5-0	72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. Do NOT use retired)	ing 16b.	Kind of Business/Industry
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1	121	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28s-f show aumatic event, the Medical Examiner must be notified at		2 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maide	Health Care
	Maryland	e d ala	Be c	Monnie James White, Sr. Beryl	(u/k)	Smith
	Z	d 2 should the and Men 7 is marks traumatic	မ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		
1	Ma	カチト				SIPING APONE
,	ā,	1 a Heg		Mary Jane Barker - Daughter 1928 Park Beach Drive 20a. Method of Disposition (Name of cemetery, crematory or other place)		Location - City or Town, State
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		To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a confidence only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a confidence of the con	and due to the cause(s) and manner as stated.
		thin 2 the mple	Med	one) and manner stated. 29b. Signature and title of certifier		
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				30 Name and address of average who completed accurate of death (form 32a) The California		1200
		2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	od Bol	Ain MA21014
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		Registr		MAR 0 3 2005		

			1 - For State Registrar	State of Maryla		artment of F			giene ())5	07073
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Oulany F	oste/				2. Date of Dea	2 / E	Year	3. Time of Death 0/36 M
	Examir Funeral	ner	5. Social Security Number 6. Sec	pital Ce	ater s. last birthday)	If Under 1 Year	estm If Under 24 H	inster		9. Birtho	lace (State or Foreign
	Director		212-10-3141 Usual Residence of Decedent 10a. State 10b. County	1M 2□F 88	Yrs. City, Town or Lo	Months Days	Hours M	lrs. 8. Date of Birtl in. (Month, Day July 9,	1916		y Land Od. Inside City Limits
	h the Maryl r 28a-f sho	Director	Maryland N/A 10e. Street and Number		altimore				10g. Citizen of \		1∭XYes 2□No
036	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show polical Examiner must be notified at	by Funeral	4413 Bedford Place 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: WW	!	2121 Was Decedent of H f Yes, specify Cuba		(Specify Yes or No- erto Rican, etc.)	Unite	e - Americ ck, White,	an Indian, etc.
d 21215-0036	d within giene. Ir than "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	cation	16a, Deced	dent's Usual Occup kind of work done of DO NOT use retired Judge	during most of v		16b. Kind of Bu	vernn	dustry
Maryland	be do la	To Be	Clarence Dulany Fos		40, 14, 15		Nell	Martin			
	ss I and 2 of Health a item 27 is r othar tree		19a. Informant's Name/Relationship (Ty. Dulany Foster, Jr., 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ R	SON 20b.	8810 Place of Dispo cemetery, cren	South Se sition (Name of natory or other place	a Oaks	Way, Apt.	405 20c. Location -	Vero	Beach, FL
Baltimore,	permit. Page Department of Importent: If any injury or once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License **Document Or Mutable **Document Or	Gr Rell	Mi	t cremato Name and Addre tchell-W 500 York	ss of Facility iedefel	.4,2005 l d Funeral Saltimore.	Home.	ce, M Inc. 212	aryland
	Physician /Medical Examiner	er	23a. Part. Enter the disease, or compliance, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Esquantially liet conditions if any, leading to immediate cause. Enter Underlying	Due to (of as a conse	ardra	l Inf	^		est,	1	Approximate Interval Between Offset and Death
68760, <	death certificate be executed attending physician and d for use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):					(lears
.O. Box	the y th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of deliver	ry Day Year
rds, P	sign sign	by	Part II. Dther significant conditions cor	tributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did to			e cause of death?
Vital Records,	The law ate has b page 2 st	e Completed	25. Was case referred to medical						med?	rior to con leath?	osy findings available inpletion of cause of 2 No
of Vi	Physiclen: this certific ral director,	To B	examiner? 1 Tes 2 No	ospital: 1 Inpatient 2 [er: 4 🗆 Nursing	Home 5 Reside	ence 6 Othe)
Division	Attending death. ctor: After y the funer	Certification:	27. Manger of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At			y at ⟨? Yes 2 □ No	28d. Describe ho	reet and Numbe		Route Number,
Ö	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier Certifying Phys	building, etc. (Spec	nowledge, death	occurred at the tim	ne, date and pla	City or Town	ause(s) and ma	nner as sta	ated.
ŧ	To the H within 24 To the F complete	Medical	29b. Signature and title of pertifier	ner: On the basis of examinand manner stated.		29c. License	number	2	9d. Date signed	(Month, C	Day, Year)
DH	Sta Registr	te ar	30. Name and address of person the co	mpleted cause of death (lite 2 9 39 Registrar's Sign	em 23a) (Type, nature	erint) Ve St	307	Westm	is te	M	D 21157

			For State Registrar	State of M	-	Departmen Certificate			and Me	_	giene	005	07074
			Decedent's Name (First, Middle	e, Last)					2	. Date of De	ath		3. Time of Death
	Physici		WILLIAN	FORE	SMA	N				Month FEB.	25,	2005	8:30 AM
	/Medic Examin		4a. Facility Name (If not institution		7		Town, or I	Location of	f Death			unty of Death	
1			2920 Stranden	Road		Ba	ltimo	ore					
	Funeral		5. Social Security Number		e (In yrs. last bir	Months	1 Year Days	If Under 2 Hours	24 Hrs. 8 Min.	Date of Birt (Month, Da	th y, Year)	9. Birth	place (State or Foreign
	Director		191-24-6657	1 XM 2□ F	75	Yrs.			- 1	PR. 6,			sylvania _
	pur 🛦		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Tow	n or Location							10d. Inside City Limits
	daryla sho	5	MD		Baltin								1 Yes 2 □ No
	28a-i	Director	10e. Street and Number		Darch	10f. Zip	Code				10g. Citizen	of What Cou	intry?
	72 hours after death with the Maryland Inatural, or Items 23e or 28e-f show Jisal Exacilizer must be notified at		2920 Stranden	Road			1230				USA		
	ms 2%	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Deced	dent of His	panic Orig	gin? (Speci	fy Yes or No	- 14.	Race - Ameri	
9	after or ite	교	1 ☐ Never Married 2 [X] Mar	ned 1 XYes 2 ☐	No	1 Yes, spec		Specify:	, Ривко кі	can, etc.)	į.	Black, White, ecity: Whi	
8	ral', c	d by	3 Widowed 4 Divorced	Year or Dates:	Army	1 1 1 42	2140	эрөспу.			Sp	ecity: WIII	
21215-0036	72 h 'natu	Completed	15. Deceder (Specify only highe	nt's Education st grade completed)	16a.	Decedent's Usua (Give kind of wo life. DO NOT us	al Occupa rk done di	tion uring most	of working	7	16b. Kind	of Business/Ir	ndustry
12	within ene. than "	шp	Elementary/Secondary (0-12)	College (1-4or	' I						D- 3-	1	
2	filled v Hygie other t		12 17. Father's Name (First, Middle,	(1951)		Photo Te			r's Name /	First, Middle,			vernment
and	d be fental h	Be	Ralph Moore F	•						Pross		,	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or thems 23a or 28a-f show or other traumatic event, If a Modical Examinet most be notified at	ဥ	19a. Informant's Name/Relations		19b	. Mailing Address	(Street a						p Code)
	and 2 sealth ar m 27 is her trau		Becky Batta -	daughter	13	5 Wild O	ak Ro	oad,	Sever	na Pai	ck, MD	2114	6
re,	f Heal f Heal fem othe		20a. Method of Disposition		cemete	Disposition (Narry, crematory or o	ne of)	Dat	te	20c. Locat	ion - City or T	own, State
E	Page ient o nt: If ry or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		Meadow.	ridge Me	m. Pa	ark	3/1/2	2005	Elkri	dge, M	D
Baltimore,	permit. Pages 'Department of Himportant: If Ite any injury or of once.		21. Signature of Funeral Service	Licensee .		22. Name an Gary L. 7250 Wa	Kau	fman i	Funer	al Hor	ne@Me	adowri	dge MP, Inc. 1075
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that cause	d the death. Do	not enter the mod	e of dying	, such as	cardiac or i	respiratory a	rrest,		Approximate Interval Between
, i	Physician		Immediate Cause (Final disease or condition	Anto	in Se	lerot	-	Can	din	Vaxcu	Can Di	reake	Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence	01):					-101	74 56	
Ľ	Examiner		Sequentially list conditions,	b. Hy	per	tens.	M						
	Si &	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):							
2	be executed irclen and burial-transit	Examine	that initiated events resulting in death) Last	c	a consequence	of):							
760,	ite be executed ysicien and ne burial-transit	cai E											
687	9 × 9			d									
Box (death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d	. Date of deliv	rery
ă	death a atte	iciai	in the past 12 months?	4□Pregnant a	2 Fetal death t time of death	3 □Ectopic pi 5 □ Other (sc						Month	Day Year
0		hys	9 Unknown	9□ Unknown						1			
S, D	The law requires thet the the bas been signed by the bage 2 should be detache	by P	Part II. Other significant condition	ions contributing to death t	out not resulting in	n the underlying o	ause give	n in Part I.	•				the cause of death?
ğ	w require been sis		renal of	alun		4.				1.502	Yes 2□N	lo 3∏Pro	bably 4 □Unknown
Record	e law re has bei ge 2 sho	Completed	Abdomin	al Aort	ic An	eury.	8m			24a. Was	osy	prior to co	opsy findings available empletion of cause of
		Con	.,							1 Yes	ormed? 2 No	death?	2 🗌 No
of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?				04-		of Death (Check only	one)		
)	shys this al dir	1º	1 Yes 2 No	Hospital: 1 Inpati		Itpatient 3 DC		4 🗆 INU		e 5 Resi		Other (Speci	fy)
	fee fee	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pendi		ay Year)	Time of a finjury	28c. Injury Work	al ? ′es 2 □ ľ		d. Describe	now injury of	ccurred	
Si	Attending in death. ector: After by the funer	icat	3 Suicide 6 □ Could		iury - At home fa	ırm, street, factor		00 2		If. Location (Street and N	lumber or Rui	al Route Number,
Division	or A effer Direction	Certification:	4 - Homicide determ	building, e	tc. (Specify)		,,			City or To	wn, State)		
	Hospital 24 hours e Funeral I			ng Physician: To the best									
	To the Hospital or Atlandl within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medica one)	Examinar: On the basis of and manner s		nd/or investigation	, in my op	inion, deat	th occurred	d at the time,	date and pla	ice, and due	to the cause(s)
	To the vithin 2 To the comple	Σ	29b. Signature and title of certifi-	to Want		29	c. License	number			29d. Date si	igned (Month	Day, Year)
)				unkara	~		12	164	9		relat	ruary	25, 2005
	11-11		30. Name and address of person	who completed cause of	death (Item 23a)	(Type, Print)		A-	, A	Otran	201	MA	25, 2005 21229
	101		OATBANDAM	13/48/KAKAW	rar's Signature	Wick	ems	ועון	1.630	RCI (VI	104,	10	/
	Sta Registi		31. Date filed (Month, Day, Year	32. Heast	rai s signature	Knowl							
		гы	MAR 0	3 2005	CHAN IS	10 may							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 ar MARCH 1, **Physician** Eleanor M. Grothe 2:50a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 33 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2√□F Maryland 212-30-5901 71 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location West 1 Tes 2 No Keyser Director Virginia Mineral 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26726 P.O. Box 1401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 2 Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 21 Married White 1 ☐ Yes 2 HNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any injury or other traumatic event, the Me ODE. College (1-4or 5+) Elementary/Secondary (0-12) Domestic 8 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be (Philip Apple Myrtle Cain ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elisha J. Grothe/husband P.O. Box 1401 Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory, Inc. 3/1/05 Baltimore, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL CELL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2□ No 26. Place of Death (Check only one) 25. Was case referred to medical ELEANOR examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state). 29a. Certifier Medical (Check only one)

DHMH 17 Rev 1/2001

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MAR 0 3 2005

TABLE MAHMOOD. 2300

32. Resistrar's Signature MAR 03 Registrar

29b. Signature and title of certifier

ORIGINAL

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIE MAHMOOD. 2300 Dulancy VALLEY RD, TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

				State of Ivid	ai yiai iu / i	Certificate of	Death		J. No.	J5 U	1016
			1. Decedent's Name (First, Middle, La	st)	·			2. Date of Deeth Month	Dey	3. Ti	ime of Death
	Physici		Ralph Zack Gil	lliam				Februar			15pm
	/Medio Examir	_	4a Fecility Neme (If not institution, giv				4b. City, Town, or I	ocation of Death	4c. County		
		ю	Franklin Square	Hospital	Center		Rosedal	<u>e</u>	Bal	timore	
	Funeral Director		5. Social Security Number 6. S 223 46 5324	Sex 7. Ag	e (In yrs. lest bii -	thday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, Y June 6, 1	^{'eer)} 929	9. Birthplace (S Country) Virgin	
	pug &	•	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10d. Ins	ide City Limits
	aho	5	Maryland Baltimo:	ro		iddle River				1 [Yes 21€ No
	the N	Je Ct	10e. Street end Number			10f. Zip Code		100	. Citizen of W	Vhat Country?	
	h with	a D	13005 Eastern Ave	enue Ext.		2122	0.0		US.	A	
Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Heelth end Mental Hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28e-f show important: if Item 27 is marked other than "naturel", or items 23a or 28e-f show important in Item 1	by Funeral Director	11. Marital Stetus 1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Detes:	No	13. Was Decedent of If Yes, specify Cu	o Specify:		Blac	e - American Indi ck, White, etc. g:White	an,
5-0	72 ho	eted	15. Decedent's E (Specify only highest gra		16e	Decedent's Usual Occ (Give kind of work don life. DO NOT use retii	upation e during most of wor	king 16	b. Kind of Bu	usiness/Industry	
121	vithin ne.	To Be Completed	Elementery/Secondary (0-12)	College (1-4or 5	5+)	iife. DO NOT use retii avy Equipme	_		erospa	CO	
2	her th	ខិ	7 17. Father's Neme (First, Middle, Last	F1	пе	avy Equipme		ne (First, Middle, Ma			
and	ntal h	Be	Coy Gilliam	,			Gertrud			,	
2	hould d Me mark matic	۲	19a. Informant's Name/Relationship ((Type, Print)	198	. Mailing Address (Stre	et a <i>nd Number or Ru</i>	rel Route Number, (City or Town,	Stete, Zip Code))
Ma	od 2 s Ith en 27 is r trau		Roger Gilliam (So			1322 Red Li					
ē,	f Hee f Hee item		20a. Method of Disposition		20b. Place o	f Disposition (Name of ry, crematory or other p.	/ace)	Date 20	c. Location -	City or Town, St	ate
E E	Peger ento nt: if i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special			Hill Mem.		3/3/2005 E	3altimo	ore, Mar	yland
Baltimore,	pemit. Depentrimports any inju		21. Signature of Funeral Service Lice	nsee	2	22. Name and Add Bruzdzins	ress of Facility ski Funera Eastern A	l Home P.	A. ex, Md	. 21221	
		Н	23a. Part1. Enter the diseese, or com shock, or heart failure. List only	polications that caused	the death. Do	not enter the mode of d	ying, such as cardiac	or respiratory arres	it,		oximate ral Between
1	Physician /Medical 	50	Immediate Cause (Final disease or condition resulting in death)	· Klebsie	Due to (or as a	DNEUMEN consequence of):	nia_			Onset	t and Death
ox 68760,	certificete be executed and ing physician end use es the buriel-trensit	n/Medicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Corona	Due to (or es a Due to (or as a	ammatur consequence of): rtery dis consequence of): ructive 1	ease			2	
m	death e ette ed for	Sicla	Part II. Other significant conditions	contributing to death b	ut not resulting i	n the underlying cause	given in Part I.	23b. Did tob	ecco use cor	ntribute to the c	euse of death?
Ö.	by the	by Physician/M	•					1 X Yes	3 2□ No	3 Probably	4 🗆 Unknown
Records, P.O. Box	Attending Physician: The law requires thet the death cen riceath. sctor: After this certificate hes been signed by the ettendin by the funeral director, page 2 should be deteched for use	Completed by						24a. Was en performe		24b. Were aut available completic of death?	prior to on of cause
	he lar e hes ege 2	E						1 ☐ Yes	2 No	1 ☐ Yes	2□ No
ta	en: T tificel tor, p	BeC	25. Was case referred to medical				26. Place of Dea	ath (Check only one))		
<u> </u>	ysici is cer direc	To E	examiner? 1 ☐ Yes 2 X No	Hospital:	ent 2 ER/O	utpetient 3 DOA	Other: 4 Nursing H	lome 5 Residen	ce 6 □Oth	er (Specify)	
Division of Vital	nding Ph ath. r: After th ie funeral	atlon:	27. Manner of Death 1 Naturel 5 ☐ Pending 2 ☐ Accident investigetic	28e. Dete of Inju (Month, De	ny Year) 28b.	Time of Injury M 1	juryat /ork? □Yes 2□No	28d. Describe how	injury occurr	red	
Divis	= 2 ft 0	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	Zoe. Flace of Inj	jury - At home, f. c. <i>(Specify)</i>	arm, street, factory, offic	е	28f. Location (Stre City or Town,	et and Numb State)	er or Rural Route	e Number,
	To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, pege 2	edicai C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	f examination er	e, death occurred et the nd/or investigation, in my	time, date end place y opinion, death occu	, and due to the cau rred at the time, dat	ise(s) and ma e and place, a	inner as stated. and due to the c	ause(s)
	withir To th comp	Me	29b. Signature end title of ceptifier	1		29c. Lice	nse number	290	1. Date signer	d (Month, Day, Y	'eer)
			1//	MIN.	21		0511.	36 Fe	bruar	у 27,	3005
	IHX		30. Neme end address of person who	completed cause of o	deeth (Item 23a)	Type, Print)		36 Fe Baltin		J	
			Dr. Kam Lun R. X	uyeung	2000 Fac	Inklin Squ	are Drive	- Baltin	rore,	mp 21	237
100	Sta Regist		31. Date filed (Month, Day, Year)	0 3 20 5	rer's Signature	. It spe					

Gilliam, Ralph

			_ For	State of Ma		d / Depart	ment of	Health a		-		005	07077
			State Registrar			Certif	icate o	f Death		Re	g. No.		
			1. Decedent's Name (First, Middle, I	ast)			10	411	2.	Date of Death Month	n Day	Year	3. Time of Death
	Physici		RICHAR	DVA	T50	n/	6-R	AY	/	MAR C	2/	2005	3,50 PM
	/Medic Examin		4a. Fecility Name (If not institution, g			41	-	, or Location of			4	County of Dea	
	LXUIIII		GOOD SAMARIT	TAN HOSPS	27794		BALT	TIMORE	=		B	ALTIN	HORE
	Funeral Director		5. Social Security Number 6 218-22-6257	1571 OF 5	e (In yrs. la		Under 1 Year onths Day		Min.	Date of Birth (Month, Day, 1/06/	Year) 192	9. Bir Cc 7 MAR	thplace (State or Foreign ountry) YLAND
			Usual Residence of Decedent										
	yland		10a. State 10b. County		10c. City	, Town or Locati	on						10d. Inside City Limits
	Mar Head	ţo	MD BALTIM	IORE	5	SPARKS							1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number				10f. Zip Code)		10	g. Citiz	en of What Co	ountry?
	th wil	al	P.O. BOX 117	'7			21	152			US	A	
	dea	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S	6. 13. Was	Decedent o	f Hispanic Orig uban, Mexican,	in? (Specif	y Yes or No-	1	 Race - Ame Black, White 	
9	after or Ite	2	1 ☐ Never Married 2 🗷 Married	1 ⊠Yes 2 □ N		10	Yes 22N			,			
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "naturel", or items 23a or 28e-f show event, the Mydical Exa ciner must be redified at	d by	3 Widowed 4 Divorced	Year or Dates:	wing							· VV	HITE
5	natu	Completed	15. Decedent's (Specify only highest)	Education grade completed)		16a. Decedent (Give kind	's Usual Occ d of work dor	upation ne during most ired)	of working	1	l6b. Kin	d of Business	/Industry
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p	S should be filed and Mental Hygi Is marked other aumatic event, I	Be	17. Father's Name (First, Middle, La					18. Mothe	rs Name (F	First, Middle, N	aloen s	ourname)	
<u>yla</u>	should be and Mental s marked o umatic eve	ဥ	WATSON W. GRA	·Υ						DAVIS			
Maryland	ges 1 and 2 should at of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship							loute Number,			
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any injury or other tra 90008.		MARY M. GRAY(WIFE)	ook Di	P.O. I		177 SF			_		
ore	of H of H if Iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	206. PI	ace of Disposition metery, cremate	on (Name of ory or other p	elace)	Date	9 2	OC. LOC	ation - City or	Iown, State
Baltimore,	mit. Pag bartment sortant: I rinjury c	1	' 4 □ Donation 5 □ Other (Spe		ST.	JAMES	CEM	ETERY_	03/0	5/200	5 M	ONKTO	N.MD.
alt	permit. Departr Imports any inj		21. Signature of Funeral Service Lic	ensée)				tress of Facility		& SON	c 0	0	
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			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused	the death	. Do not enter t	ne mode of d	ying, such as	cardiac or r	espiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	P	umor								Onset and Death
Į.	/Medical		resulting in death)	Due to (or as									
	Examiner												
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	uted d ansit	Examiner	Cause (Disease or injury that initiated events	c									
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99	death certificate t attending physical for use as the t												_
Вох	ndin use	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			topic pregna	2014			2	3d. Date of de	livery
	death	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			her (specify)					Month	Day Year
P.O.	that the deled by the a	hys	9 ☐ Unknown	9□ Unknown							-		
	The law requires that the tte has been signed by the bage 2 should be detache	Completed by Physician/Medi	Part II. Other significant condition	1 // /		Iting in the unde	rlying cause	given in Part I.		23e. Did tob	acco us	e contribute to	the cause of death?
ğ	n sig	D D	Acute Kenn	1 trilux	e_					1 🗌 Ye	s 2\	No 3 □ P	robably 4 Unknown
S	w rec	lete								24a. Was ar		24b. Were as	topsy findings available
Re	The lav	m d								autopsy	red?	death?	completion of cause of
Division of Vital Records		e C	25. Was case referred to medical					26 Place	of Death (1 ☐ Yes 2 Check only one	No No	1 L Yes	31 No
₹		00	examiner?	Hospital:	ant 2 🗂 I	ER/Outpatient	3 DOA	Thor.	- Proces	5 🗋 Reside		Other (See	city)
of	Phy r this	. To	27. Manner of Death	28a. Date of Inju	iry	28b. Time of	28c. In	jury at		d. Describe ho			
on	ding h. Afte fune	tlor	1 Natural 5 Pending 2 Accident Investiga	(Month, Da	y Year)	Injury		Vork? □Yes 2⊡1	No				
S	Attending r death. ector: After by the funer	ertification:	3 Suicide 6 Could no	t be 28e. Place of Inj			factory, office	28	281			Number or R	ural Route Number,
<u>S</u>	or A after Dire	erti	4 Homicide	building, etc	c. (Specify)				City or Town.	State)		
_	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	O	29a. Certifier ☐ Certifying	Physician: To the best	of my know	wledge, death or	curred at the	time, date and	d place, and	d due to the ca	use(s) a	and manner as	s stated.
	Hos 24 h Fur tely	edical		caminer: On the basis of and manner sta	f examinat								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. 1			29c. Lice	nse number		29	d. Date	signed (Mont	h, Day, Year)
)	ĕ → ĕ →		Monte	Then 1	40		Doc	537	22		MAN	(01	2005
7			30. Name and address of person w	no completed cause of a	teath (Item	23a) (Type Prin	nt)				100	/	
	0.0		TEF IFU	J. PILL			LA	146	41/.	BXIL	2/	90 9	2127.
	Sta	to.	31. Date filed (Month, Day, Year)	22 Pagists	ar's Signal	LIFO		7 . 10 . 10	10	4 6 4		U)	
	Regist		MAD 03 1	2005 Balles	a d	" Som	es.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 20 Walter John Geraghty Frebrugn 2005 27 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris @ Mercy Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days June 5, Director 219-12-9679 80 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ahov the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 236 3649 Kenyon Avenue 21213 S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Yes 2 □ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Year or Dates 1945 - 1975 White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Military Service othar traumetic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Geraghty Margaret Seidler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 tr of Health a tram 27 I Satoko Geraghty (Wife) 3649 Kenyon Avenue, Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ŏ Garrison Forest Va. Cem. 3/08/2005 Owings Mills, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) no sta Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): 68760, physician Physician/Medical the Box IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O.4 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 Yes 2 No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 of this in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Division 1 🗖 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours a To the Funaral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 128/2005

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Riseberg

MAR 0 3 2005

31. Date filed (Month, Day, Year)

301

ST

32 Registrar's Signature

40854

Baldemore

		State of Maryland / Dep	artment of Health and M	lental Hygien	/ 11115	07079
		1. Decedent's Name (First, Middle, Last)	11110010	2. Date of Death		3. Time of Death
Physic		Raymond G. Gorschboth		Month D March	1. 2005	7:30 A ^M
/Med Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	
Exam		2308 Eastridge Road	Timonium	1	Baltimore	
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea		place (State or Foreign ntry)
Director		217-18-5939 /9		Apr. 4, 19	925 Mar	yland
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
Maryl f sho	Ď	MD Baltimore Timonium				1 ☐ Yes 2火☐ No
r 28a	rec	10e. Street and Number	10f. Zip Code	10g. 0	Citizen of What Cou	ntry?
h with	ai D	2308 Eastridge Road	21093	US	SA	
deat	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
or It		1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No Specify:		Specify: W	hite
IC X IX IS-UUSO I filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or Items 23a or 28a-f show rent, the Madical Exprimer must be coulded.	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b	Kind of Business/Ir	
n 72 in 72	olete	(Specify only highest grade completed) (Give	kind of work done during most of worki DO NOT use retired)	ng	Talla of Daoinood!	
withi iene. iene. than	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 11 Print	er	The	e Baltimo	re Sun
filed Hyg other	0	17. Father's Name (First, Middle, Last)		(First, Middle, Maide	en Sumame)	
Id be Aenta rked tic ev	To B	Raymond G. Gorschboth	Martha C			
DESILIMOTE, INIGITY IGNO ZIZIO-JOUGO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exprinter must be revitified at		1.1.1.	ng Address (Street and Number or Rura			p Code)
and and ealth m 27			Eastridge Road; T		Location - City or T	oum State
Dallimore Demit. Pages 1 Department of He mportant: If iten iny injury or oth		1 MBurial 2 Cremation 3 Hemoval from State	matory or other place)			Own, State
ti Pa ti Pa rimen rimen riment: rimit:			Cemetery 3/5/0 2. Name and Address of Facility		ndalk, MD	Dand
Dal permi Depa Impo Impo			uck Towson Funeral		l050 York Towson, Mi	
		23a. Part 1. Ent in the disease, or complications that caused the death. Do not en			iowson, Ph	Approximate
		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	7			Interval Between Onset and Death
Physician /Medica		disease or condition resulting in death) Due to (or as a consequence of):	3			& Week
Examine	7	Porita	with's			2 weeks
	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	, ,			- 1
nd left	Examiner	that initiated events c. Sovel 3	Estruction			2 wells
If ou , Ite be executed sysician and ne burial-transit		resulting in death) Last Due to (or as a consequence of):	1.			2 /2 hr
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	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	/erv
death cer death cer e attendir	cian	in the past 12 months?			Month	Day Year
the d	ysic	1 Yes 2 No 9 Unknown				
	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
rds quires n sign uld be				1 ☐ Yes	2 No 3 Pro	bably 4 Dunknown
> 0 0	ompieted			24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
0 - 0	E O			performed?	? death?	
ysician: Thysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?		(Check only one)		
l di	To	1 ☐ Yes 2 € No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			6 □Other (Speci	fy)
On O	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	ijury occurred	
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LIVISION I or Attending after death. Director: Afte	Certificati	4 Homicide determined building, etc. (Specify)	neer, ractory, cirios	City or Town, Sta		
spital nours neral		29a. Certifier TS Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cause	(s) and manner as	stated.
DIVISION OF To the Hospital or Attending President 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, date a	and place, and due t	to the cause(s)
To # To #	W	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
		Jane Charge no	D16587	7	much 2,	2005
6+1		30. Name and address of person who completed cause of death (Item 23a) (Type	Printy Ste 302,	Tomorean	MADIO	104
9.		You (hand, was 7505 05 cm b)	THE SUL,	((()	10000	
S Regis	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	sele			
. logic	-	MAR 0 3 2005 Degras St. 19	_ • -			

DHMH 17 Rev 1/2001

			For	State of Maryland	d / Departmer	nt of Health and M	Mental Hygier	ne a a a r	
		1	State Registrar		Certificat	e of Death	Reg.	No. 2005	0/080
	Physicia	_	1. Decedent's Name (First, Middle, Las	")		(2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al -	Brian	-tract and aumbarl	4b City	Town, or Location of Death	rebruary	4c. County of Deetl	2355
4	Examin	er	4a. Fecility Name (If not institution, give	Wine Warn	to / Box	LIMARA !	iti	,	
	Funeral Director	2	5. Social Security Number 6. \$6. \$6. \$6. \$6. \$6. \$6. \$6. \$6. \$6.	7. Age (in /rs. li	ast birthday) If Under Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth	ar) 9. Birth	nplece (State or Foreign untry) ary and
	yland		Usual Residence of Decedent 10a. State 10b. County	10c, City	r, Town or Location				10d. Inside City Limits 1 ★es 2 □ No
	8a-f e	Funeral Director	MD	13	altinu	ove -	100	Citizen of What Co	
	with the		10e. Street and Number	usida D	Ocal 101.21	Code	TOG.	/15A	unity :
	death	nera	11. Marital Status	12 Was Decedent Ever in U.: Armed Forces?	S. 13. Was Dece	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer Black, White	
9	be filed within 72 hours after death with the Maryland nat Hygliene. de other than "natural", or Itama 23a or 28a-f show event, The Madical Exantractional be natified at		1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes	• /	,	Specify:	lack
Ö	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. Decedent's Usi	ial Occupation	166	. Kind of Business/	Industry
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7	filed wit Hygiene ther the	Соп	104h		(D) 17	ractor	DC. ne (First, Middle, Maid	7 0	s Electric
Maryland	ed is b	To Be	17. Father's Name (First, Middle, Last)	WY		Evel	YN Ma	Hher	JS
lary	permit. Peges 1 and 2 should Department of Health and Mer Important: If item 27 le marke any injury or other traumatic QRE8.		19a. Informant's Name/Relationship	/	1	S (Street and Number or Re	Route Number, Ci	ty or Town, State, Z	Zip Code)
_	1 and Health iem 27	-	20a. Method of Disposition	Suy (Mother	lace of Disposition (Na	Shadysid	Date 200	Ballo / Location - City or	Town, Stete
Baltimore,	Peges nent of I int: If it		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specifi		emetery, crematory or	other place)	3/4/05	R. Osh	·MO
altir	permit. Peg Depertment Important: any injury c		21. Signature of Funeral Service Licer		2/20°	nd Address of Facility	0,10 FZ	ueral S	ervices
<u>~</u>	Depe Impo		KACL	7+1,	490	5 YORL RI	J. Bulto	MD 212	12
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the death one cause on each line.			or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequ		5+			30 minutes
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7	₽ ₩	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ		-			1
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8760	ate be executed obysician and the burial-transit	ical E		d					
9		Medi	IF FEMALE:						
Вох	death certific e attending pl d for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of de	I death 3 □Ectopic			23d. Date of dei Month	ivery Day Year
P.O.		nysic	1 Yes 2 XNo 9 Unknown	9□ Unknown	eath 5 Other (:	spacity)			
	uires that the signed by th d be detache	by Pt	Part II. Other significent conditions of	ontributing to death but not resi	ulting in the underlying	cause given in Part 1.			the cause of death?
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Records,	0 2 0	Completed					24a. Was an autopsy performed	death?	utopsy findings available completion of cause of
ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				ath (Check only one)		
of V	Physician: this certific ral director,	ို	1 ☐ Yes 25 No		ER/Outpatient 3 0		fome 5 ☐ Residenc		cify)
Division of Vital	ling After une	Certification:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 Yes 2 No	200. Describe now	injury occurred	
Visi	after death. I Diractor: After	ifica	3 Suicide 6 Could not be determined	e 290 Place of Injury At he	ome, farm, street, factor	ory, office	28f. Location (Stree City or Town, S		ural Route Number,
Ö	ital or irs afte rel Dir								
	To the Hospital or within 24 hours aff To the Funerel Di completely filled in	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Examone)	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	s stated. s to the cause(s)
	Mithin Fo the	Med	29b. Signature and title of certifier		-	9c. License number		Date signed (Mont	•
)			by you you	m, mo		Des-000 olte street	Feb	ruary 2	7,2005
	3		30. Name and address of person who	completed cause of death (Item	m 23a) (Type, Print)	10 (ca.)	D = 11.	- 71/1 00	1007.0101
4		ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature At w	Olls STREET	Battmo	45 MM1 34	107 1106
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 3 2	2005 Been 1	of speak				

			For State Registrar	State of Maryland / Dep	partment of Health and I e <i>rtificate of Death</i>	Mental Hygie _{Reg.}	2005 07001
	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 1920 M
	Physicia /Medic		Roland Peacoc			KEBRUARY	2/1244
	Examin	er	4a. Facility Name (If not institution, give s SAINT AGNES : HE	treet and number)	4b. City, Town, or Location of Death		4c. County of Death n/a
	Funeral		5. Social Security Number 6. Sex		y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
	Director		214-38-0486]M 2□F 64 Yrs.	Months Days Hours Min.	Jan. 05,	1941 Baltimore, MD
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Maryl f sho	to	Maryland Baltimor	te Lansdowi	20		1 Yes 2 □ No
	r 28a	Director	10e. Street and Number	e Lansdown	10f. Zip Code	10g.	Citizen of What Country?
	23a c	raiD	363 Bigley Avenue		21227		USA
	er dez Items Der D	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other treumetic svant, the Medical Evanter must be notified at once.	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates: Peacetime	1 ☐ Yes 2 ☑ No Specify:		Specify: White
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a, Dec	cedent's Usual Occupation ve kind of work done during most of wor b. DO NOT use retired)	rking 16t	c. Kind of Business/Industry
121	within ne. .han	шp	Elementary/Secondary (0-12)	College (1-4or 5+)			1
	filed v Hygie vthar t		17. Father's Name (First, Middle, Last)	Dr:	iver 18. Mother's Nar	ne (First, Middle, Mai	altimore City den Sumame)
Maryland	lid be lental rkad c	To Be	Louis Wil	liam Glatth	naar Audrey		Peacock
lary	and N and N Is mai	ſ.,	19a. Informant's Name/Relationship (Ty		illing Address (Street and Number or Ru		
	fealth im 27 har tr		Pauline C. Glattha		Bigley Avenue, Lar	-	aryland 2122/
סב	ages 1 tof H: Hita		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	enioval from State	position (Name of rematory or other place)		
Baltimore,	artmer prtent injury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 		rematory Inc. $3/4$		ltimore, Maryland Funeral Home
Ba	Depar Depar Impor any ir		1		3620 Wilkens Ave.		
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not ene cause on each line.	enter the mode of dying, such as cardiad	or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	myocardial	infarction		Vnlinaun
	/Medical Examiner		resulting in death)	Due to (or a a consequence of):			
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
	cuted nd ransit	Examin	cause. Enter Underlying Cause (Disease or Injury that initiated events	s			
90,	icate be executed physician and s the burial-transit	i Ex	resulting in death) Last	Due to (or as a consequence of):			
68760,	icate t physk	dicai		1			
Box (death certific e attending p ed for use as 1	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	3 ⊡Ectopic pregnancy		23d. Date of delivery
Ö.	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		5 Other (specify)		Month Day Year
P.O.	res that the de signed by the a be detached f	Phy	9 Unknown Part II, Other significant conditions con		a underlying cause given in Part I	23e. Did tobac	co use contribute to the cause of death?
ds,	The law requires that the ste has been signed by the bage 2 should be detache	d by	Fatti. Other significant contamons con	REPORTED TO COME OF THE COME O	s and onlying database given in a care		2 No 3 Probably 4 Unknown
Records,	w require been sign	lete				24a. Was an	24b. Were autopsy findings available
	The lav	Completed				autopsy performed	
Vital		BeC	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one)	
) t	Physician: rthis certific ral director,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		lome 5 Residence	e 6 Other (Specify)
on (ing After	tion:	27. Manger of Death 1 Natural 5 Pending investigation	28a. Date of Injury 28b. Time (Month, Day Year) Injury	y Work? M 1 □ Yes 2 □ No	280. 0630106 11010	injury occurred
Division of	or Attending after death. I Director: After d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number,
Ö	rs after al Dire	Cert	4 Holmicide	building, etc. (Speciny)		0.19 0. 10.111, 0	
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical		sicien: To the best of my knowledge, de ner: On the basis of examination and/or			
	ithin 2 o the	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	29d.	Date signed (Month, Day, Year)
)	- 3 - ö		In tal	- M	D47353	F	ebruary 27,2005
	511/			ompleted cause of death (Item 23a) (Type	pe, Print)	Jan 217	ebruary 27,2005
4	101		31. Date filed (Month, Day, Year)	4		100,01 511	1
0.5 0.5 5.,	Sta Registr		MAD 0.3 701	No. Add	food		

GLATTHARR, RUMND

			1- For State of Maryland / Dep Registrar Ce	artment of Health and M rtificate of Death	Reg.	711115	07082
	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Elmer L. Gibson		2. Date of Death Month Feb 25,	Day Year 2005	3. Time of Death 1:25 P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deali	
			Waldorf Healthcare 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Waldorf If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Charles	Simplace (State or Foreign
	Funeral Director		579 26 3646 XX 78 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes Feb 12,	1926 New	Jersey
	and w.		Usual Residence of Deceden! 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary B-f sho	tor	Maryland Prince George's Clinto	n			1 ☐ Yes ŽŒNo
	th with the 23s or 28	Funeral Director	10e. Street and Number 9609 Gwynndale Drive	10f. Zip Code 20735		Citizen of What Co ited Stat	,
36	be filed within 72 hours after death with the Maryland stal Hygiene. do other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, its Modical Examinar must be motified at	by Funer	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
21215-0036	within 72 hou lene. than "natura its Mudical E	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	. Kind of Business/l	ndustry
21	filed withi Hygiene. Sther than		12 2 Co	ntractor	He e (First, Middle, Maid		Air Conditio
land	ould be fi Mental H arked otl	To Be	17. Father's Name (First, Middle, Last) Ransom R. Gibson		Ann Gorman		
Maryland	and and em	-		ng Address <i>(Street and Number or Hure</i> 66 A Huntingdon Dr			
Baltimore,			Aguilar 2 Cignation 3 Chambrail Tom State	osition (Name of matory or other place) March tion Cemetery		Location - City or I	
Balti	permit. Page Department of Important: If any Injury or QDC9.		21. Signalure of Funeral Service Licensee	2. Name and Address of FacilitLee Alexandria Ferry R	Funeral Ho	ome,Inc 6	633 Old
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in dealh) a	1001			
	Examiner	ler	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	te be executed ysician and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	ate be only siciar the buri	dical E	d				
O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deline	very Day Year
ds, P.	uires that signed by	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc		the cause of death?
Records,	The law requires ate has been sign page 2 should be	Completed	coloning and of season		24a. Was an autopsy performed	prior to c death?	opsy findings available ompletion of cause of
Vital	ician: T certificat rector, pa	BeC	25. Was case referred to medical examiner?		(Check only one)		
of	Phys rthis ral dii	on: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending	of 28c. Injury at Work?	me 5 Residence 28d. Describe how in		ify)
Division	Atten or deat octor: by the	Certification:	Accident investigation 3 Suicide 6 Could not be delemined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, Sta		ral Route Number,
ш	ospita hours uneral y filled	edical Ce	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea (Check only 2 Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, executions, in my opinion, death occurr	and due to the cause	e(s) and manner as	stated. to the cause(s)
	To the He within 24 To the Fu	Med	one) and manner stated. 29b. Signature and fille of certifier	29c. License number	29d. [Date signed (Month	, Day, Year)
(31		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) three (Intr	Walder	f M	70602
1	Sta Registr		31. Date filed (Month, Day, Year) MAR 0.3 2005	relles	,		

			For State Registrer	State of Ma	arylan		artment of rtificate of	Health and M	•	giene Reg. No.	05	07083
			1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	nath Day	Year	3. Time of Death
	Physicia /Medic			Irma	Z	A. Gu	zzi		08-	25 -	05	9:47 am
	Examin	100	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town,	or Location of Death)		ty of Death	
			Franklin Square	Hospital Co	nte	~	Kosedi	ak		Bal	timon	e
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs.	last birthday,	If Under 1 Yea Months Days		8. Date of Bir (Month, Da	th v, Year)	9. Birth	place (State or Foreign ntry)
- 0	Director		204-12-7379	□ M 255xF	91	Yrs.	Mionana Baye	110010		4,1913		nnsylvania
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10a Cit	y, Town or L	anatio n					10d. Inside City Limits
	ith the Marylar or 28a-f show e notified at	_	,	imore	100.00	y, rown or c		Parkville				1 ☐ Yes 2√ No
	Ba-f	Director	Maryland	THOLE								
	or 2	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show Littus! Le ncillied at		9117 Hines Road					21234		Unite		
	ter dea Itams	Funerai	11. Marital Status	12. Was Decedent 8 Armed Forces?		.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No o Rican, etc.))- 14. R B	ace - Ameri lack, White,	
Z 8	ours after dearal', or Itams	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ N If Yes, Give	lo		1 ☐ Yes 2 ☒ No	o Specify:		Spec	ify:	
Irma 215-0036			3 ⊠Widowed 4 □ Divorced	Year or Dates:		10- D	de alla Decel Occ			405 165 4 4		ite
1 7 1	"nat	Completed	15. Decedent's E (Specify only highest gra	ide completed)		(Give	dent's Usual Occi kind of work don DO NOT use retir	upation e <i>during m</i> ost of worl red)	king	16b. Kind of	Business/in	idustry
7 5	withir ne. ihan	ш	Elementary/Secondary (0-12)	College (1-4or 5	+)							
	filed v Hygie other I		6 Years 17. Father's Name (First, Middle, Last			H	omemaker	18. Mother's Nam	ne (First, Middle	Own Maiden Sumi		
u_{22}	2 should be filed withir and Mental Hygiene. Ie markad other than aumatic evant, I.a.M.	Be										
$\sim \frac{1}{2}$	should ind Men ind Men ind marka	은	John Andreoni 19a. Informant's Name/Relationship (Tuno Print)		10h Maili	na Address /Stro	at and Number or Ru	line Bis			Code)
2 E	12 st h and 7 ie r traur		Linda W. Smith	/ Niece				s Road Ba		,		21234
	s 1 and 2 should be filed within 72 hr Health and Mental Hygiene, tiem 27 ie markad other than "natu other traumatic event, I'm Musical		20a. Method of Disposition	\ Niece	20b F		osition (Name of		Date	20c. Location		
or o	ges tof the lift ite		1X Burial 2 ☐ Cremation 3 ☐	Removal from State	0	emetery, cre	matory or other pl	lace)	54.0	200. Location	1. Only of 1	omi, State
<u>.</u> <u>E</u>	men tant:		' 4 ☐ Donation 5 ☐ Other (Specif		Mar			3/1/2005		Dur	yea, I	PA
(Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Lice	Mas	se	4 7	2. Name and Add uda-Ruc 922 Wise	ress of Facility k Funeral e Ave. Du	Home of	Dunda Marylan	lk, Ind 21	nc. 222
- 1			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the deat	n. Do not en	ter the mode of dy	ying, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ser	515							Onset and Death
	/Medical		resulting in death)	a Due to (or 🖘	a conseq	uence of):) or order
	Examiner		Conventially list conditions	Isch	emic	Col	tis					1-2 days
. /		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseq	uence of):						1 2 1
DV.	te be executed ysician and te buriat-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· Houte	B.e	nal +	ailure					1-2 (Vays
0	an ar rial-t		resulting in death) Last	Due to (or as	a conseq	uence of):						
760	cate be ex ohysician the buria	cai		d								
89		led										
P.O. Box 68	or Attanding Physician: The law requires that the death certifics there death. Diractor: After this certificate has been signed by the attending phin by the funeral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			☐Ectopic pregnan	cv		1	ate of delive	*
	ie deat the att	ici	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at 9☐Unknown			Other (specify)			^	Month	Day Year
Ö.	that the de ed by the detached	hys	9 ☐ Unknown									
	res that the signed by t I be detach	by F	Part II. Other significant conditions	contributing to death be	ut not res	ulting in the u	inderlying cause g	given in Part I.	23e. Did t	obacco use co	_	he cause of death?
Ę	w require been sig should b	ed	Hupertension						1 🗆 '	Yes 2 No	3 🗌 Prob	pably 4 □Unknown
Division of Vital Records,	aw requisits been 2 should	Completed							24a. Was	an 24b	. Were auto	ppsy findings available impletion of cause of
Re	The la	mo							autor perfo	rmed?	death?	
ta	ding Physician: The lav n. After this certificate has funeral director, page 2	e C	25. Was case referred to medical					26. Place of Dea				22.10
5	s cert	0 8	examiner?	Hospital:	nt 2	ER/Outpatie	nt 3 DOA C	thor	ome 5 Resi		ther (Specif	(v)
of o	Phye er this eral di	-	27. Manner of Death	28a. Date of Injur	v	28b. Time o			28d. Describe			,,
o L	nding F th. : After s funera	it lo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	/ Year)	Injury		ork/ ☐Yes 2 ☐No				
<u> S</u>	r Attandi er death ractor: A by the fu	fice	3 ☐ Suicide 6 ☐ Could not b	286. Place of Inju			reet, factory, office	9	28f. Location (Street and Nun	ber or Rura	al Route Number,
ρi	al or afte Dira	Certification:	4 Homicide	building, etc	c. (Specir	Y)			City of 101	WII, State)		
	To the Hospital or Attanu within 24 hours after deatl To the Funaral Diractor: completely filled in by the	edical (nysician: To the best on niner: On the basis of and manner sta	examina							
	within 2 To the	Me	29b. Signature and title of certifier					nse number		29d. Date sign	ed (Month,	Day, Year)
	->-0		1/1/1/	1111	A		D	54736		2/04	110-	
	3		30. Name and address of person who	completed cause of A	eath (Item	1 23a) (Type.	Print)	1		1/03	, , ,	
			Dr. Kanlika Aust	1100 /91	100	canVI	Bound	TO Drive D	a Himore	Md.	2173	37
	Sta	te_	31. Date filed (Month, Day, Year)	2. Registra	ar's Signa	iture	- July	CULTUIN	~ I IIIIIVIC	1 - 6	-, 0	
	Registr		MAR 0 3 2005	Block	St.	Good	V	reDrive Bo				

State of Maryland / Department of Health and Mental Hygiepe 1 - State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** FEB. 2^{Day} 2005 Arlene M. Greger 8:35 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside Health of Friendship Hanover Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Control Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 216-10-4266 1 ☐ M 2 🖫 F 84 Director JUNE 4, Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or iteme 23s or 28e-f show other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2216 Schindale Avenue 21076 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be fifed within 7. In and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William R. Schindele Theresa Antlitze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If item 27 is i Doris Smith - daughter 189 Southwood Road, Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Meadowridge Mem. Park 2/28/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home@ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIOMYOPATHY ISCHEMIC RS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HIP DAVS FRACTURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit HYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 YRS Physician/Medical HEART IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ίο in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ FIBRILLATION 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 □ No 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral c 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: Injury 1 _Natural 5 Pending after death. 12:45 PM 1 ☐ Yes 2 No PATIENT FELL AT HOME investigation 2 Accident 15/2005 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 21076 2216 SHINDALE AVE, HANOVER, MD AT HOME 24 hours a 29a. Certifier ៲ 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 22832 my 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOON JAKIM 5808 MAIN STREET, ELKRIDGE, MD 31. Date filed (Month, Day, Year) MAR 03 2005 Registrar

		-	For State		State	of Mai	ryland /		irtment d <i>tificate</i>		th and M ath	lental F	lygie Reg.		05	07085
			1. Decedent's Name (Firs	t Middle La	st)			00,	inouto	0, 000		2. Date of		. NO.		3. Time of Death
	Physicia	an	Kichard	1, 1, 1, 1, 1	1	6	rayes					Tebrua		Day 26,2	Year	4:30pM
	/Medic		4a. Facility Name (If not in	etitution aiv	e street and n				4b. City. To	wn. or Loca	ation of Death	1000	- 1	4c. County		7.27
	Examin	er				annoen)				imore	mon or boam				or Douil	
			Bon Secours 5. Social Security Number			7 Age	(In yrs. last t	irthday)	If Under 1		Inder 24 Hrs.	8. Date of	Birth		9. Birtho	lace (State or Foreign
	Funeral Director		226-09-6573	1 1		gu	90	Yrs.	Months [Days Ho	ours Min.	(Month,	Day, Y	1914	Coun	ry) Vland
			Usual Residence of Dece									AUG.	20,	エノエエ	rici	yzara
Mand	Mo M		10a. State 10b.	County			10c. City, To	wn or Lo	cation						1	Od. Inside City Limits
Man	동절	ţo	MD I	3altim	ore											1 ☐ Yes 2X No
the	r 28a	Director	10e. Street and Number						10f. Zip Co	ode			10g	. Citizen of V	Vhat Coun	try?
wit	38.0	0	1119 Raver	n Driv	е				212	27				USA		
death	as 2	Funerai	11. Marital Status		12. Was De Armed F	cedent Ev	ver in U.S.	13. V	Vas Deceden	nt of Hispan	ic Origin? (Spexican, Puerto	ecify Yes or	No-		e - Americ	
after c	or the	Ē	1 Never Married 2	Married		2 🗆 No	o		Tes, specily		ecify:	rican, etc.,				nite
3 in	<u>a</u> <u>a</u>	þ	3 ☐ Widowed 4 ☐ D	oivorced	Year or		ARMY		10 163 25	Alvo Sp	ecny.			Specify	. WI	irce
2 2 2	lical in	Completed		ecedent's E	ducation ade completed	()	16	a. Deced	lent's Usual (Occupation	most of work	ina	16	b. Kind of Bu	usiness/Ind	dustry
thin I	Man *	p d	Elementary/Secondary			(1-4or 5+	-)				most of work	,		_		
¥ 7	orth erth 1, pe	Son	12					Wat	tch Re							ch Shop
5 ∯	al Hy roth vant	Be (17. Father's Name (First,								Mother's Name			iden Suman	ne)	
B B	Ment rkac rtic e	2	Richard B	. Grav	es						Mary S.	Walt	ers			
a sho	and s	1 4	19a. Informant's Name/R	lelationship (Type, Print)				-		lumber or Run			ity or Town,	State, Zip	Code)
and;	aalth n 27 er tr		Virginia Gra	aves -	wife						, Balti			2122		
3 + S	e ii ii		20a. Method of Disposition 1 XBurial 2 □ Cre		Domoval from	n Stata	20b. Place ceme	of Dispo tery, cren	sition (Name natory or othe	of er place)	-	Date	20	c. Location -	City or To	wn, State
Page	nent Int: It		`4 □Donation 5 □ 0			ii State	Meador	wride	ge Mem	• Par	k 3/2/	/2005	1	Elkrid	ge, N	1D
permit.	Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic evant, the Medical Exemplest must be notified at once.		21. Signature of Funeral	Service Lice	nsee	~c~	~	Ga1	Name and	Address of Kaufm	Facility an Func on Blvc	eral H	ome krie	@ Mead	owric	geMP, Inc.
			23a. Part1. Enter dis shock, or heart failu	ease, or com	plications that	caused t	the death. D									Approximate Interval Between
	etete.e	1	Immediate Cause (Final	ire. List only	one cause on	each line	e choo	vic d	Lanci	2/10 01	ulmono	1000	isp	a Co		Onset and Death
	ysician Medical		disease or condition resulting in death)	-	a. Due to	o (or as	consequence		031100		W HI DE IC	1			-	
Ex	aminer			- 1		1.0	1			1						
		ē	Sequentially list condition if any, leading to immedi- cause. Enter Underlying Cause (Disease or injury that initiated events	ns, ate	b. Due to	o (or as a	consequenc	e of):								
uted	ansit	声	Cause (Disease or injury	1	C											
cate be executed	physician and the burial-transit	Examiner	resulting in death) Last	- 1	Due to	o (or as a	consequenc	e of):								
9999	/sicia e bur	dicai		•	d											
ificat	g ph) as th													-		
The law requires that the death certification	been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent preg	nant	23c. If yes, o		of pregnancy 2 Fetal dea	th 3	Ectopic preg	nancy					te of delive	
deat o	e atte	icia	in the past 12 montl 1 ☐ Yes 2 ☐ No	hs?	4□Pre	gnant at t	ime of death		Other (spec					Мо	nth	Day Year
. å	by the	hys	9 Unknown		9□Unk	nown						-				
s tha	peul e del		Part II. Other significant	conditions	70			in the u	nderlying cau	ise given in	Part I.	23e. C	id tobac			ne cause of death?
	on sig	ed k	Cormary	arre	ry di	slus	٠.					1	☐ Yes	2 🗌 No	3 🗌 Prob	ably 4 Donknown
ecords, law requires t	s bee	ompleted by	U		U							24a. V	Vas an utopsy	24b. \	Were auto	psy findings available inpletion of cause of
ב פַּ	age 2	E										p 1□ Ye	erform <u>e</u>	d? (death?	2□ No
VICIAN:	ifficat or, p	O	25. Was case referred to	medical						26.	Place of Deat			2110		
Sicie	s cer direct	0 B	examiner? 1 □ Yes 2 ☑ No		Hospital:	Inpatien	nt 2 ER/	Outpatien	it 3□ DOA	Other: 4	□ Nursing Ho	me 5 🗆 F	tesidend	e 6 □Oth	er (Specif	y)
o f	arthi eralo	Ë	27. Manner of Death		28a. Dat	e of Injury	y 28t	. Time of		. Injury at Work?		28d. Descri	be how	injury occur	red	
6	ith. :: Aft	atto	1 Matural 5 [2 ☐ Accident	☐ Pending investigation		nini, Day	7 601)	mjury	М	1 🗀 Yes	2 □No					
UNISION or Attending	acto by th	ij	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not to determined	259. Pla	ce of Inju	ry - At home, . (Specify)	farm, str	eet, factory,	office			n (Stree		er or Rura	l Route Number,
a o la	s afte	Certification:	4 E HOIMEIGE		Cui	iding, oto.	. (Opcony)							,		
Hospit	within 24 hours after death. To the Funaral Diractor: After this certificate has I completely filled in by the funeral director, page 2	ledical (hysicien: To t miner: On the and ma		examination									
o th	vithin Fo th compl	₹	29b. Signature and title	of certifier					29c.	License nur	nber		29d	. Date signe	d (Month,	Day, Year)
_	> F 0		> Lille	WIL	> . H	edica	1 Hous	P M.	hicor	1)45	148		1	ebillo	2.2	6,2005
	111	1	30. Name and address o	f person who	completed ca	use of de	17	4	Print)	/ `	¥	٨	<u>`</u>		0 -	
	511		Kicardo Os	SULVO	2000 U		Baltim	910		timors	Mary	1 land	2	2122	3 -	
	Sta	ate	31. Date filed (Month, Da	ay, Year)		Registra	r's Signature		A							
	Regist		MA	R 03	2005		per S	1. 14	parte	P						

			Please Type or Prin				Ensure A	_	-	. 07000
			1 - State Registrar	arytaria /		tificate of			Reg, No.	0/086
ш			Decedent's Name (First, Middle, Last)					2. Date of De	ath Day Yea	3. Time of Death
	Physicia /Medic		Margaret P. Herrmann					Februa	1426,200	5 5:53pm
	Examin	1	4a. Facility Name (If not institution, give street and number)		1	-	r Location of Death	1	4c. County of De	
		12.	Franklin Square Hospita 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last I	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bin	Baitir	
	Funeral Director		219-20-9156 1□ M 2XIF	82	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da April (6, 1922 Ma	irthplace (State or Foreign Country) Lyland
70	2		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	aum or Lo	antion				10d. Inside City Limits
a la co	shov	70	10a. State 10b. County Maryland Baltimore	Toc. City, 10	JWII OI LO	Perry	На Р Р			1 ☐ Yes 2 X No
404	28a-f	Director	10e, Street and Number			10f. Zip Code	nac		10g. Citizen of What	Country?
Good within 75 hours after don't with the Mendand	3a or	Ö	8 Bangert Avenue				21128		u.s	.A.
000	ms 2	nera	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Decedent of H	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No	- 14. Race - Ar Black, Wi	nerican Indian,
2	or Ite	by Funeral	1 Never Married 2 Married 1 Yes 2 🛣		1	1□Yes 2□XNo		- · · · · · · · · · · · · · · · · · · ·	Specify:	white
	tural',		3 ₩ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education	16	fa Decec	ient's Usual Occup	nation		16b. Kind of Busines	ss/Industry
5	n "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4ors		(Give	kind of work done DO NOT use retire	during most of wor	king	, , , , , , , , , , , , , , , , , , , ,	,
7 7	giene sr tha	mo:	12th grade	,,,	Nur	ses Aide			Hospita	l
2 3	Mental Hygiene. arked other that atic event, the h	Be	17. Father's Name (First, Middle, Last) Benjamin Franklin Pearce				18. Mother's Nan Nelli		, Maiden Sumame) Celer	
7 2	and Meni is marke	ပို	<u> </u>		OF 14-11-	- Address (Chrost			er, City or Town, State	Zin Codo)
	5 4 3 6		19a. Informant's Name/Relationship (Type, Print) Mrs. Linda Gonce (daught						, MD 21128	, zip code)
υ .	permin. rages I and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of natory or other place		Date	20c. Location - City	or Town, State
5	rages nent of l int: If its iry or o		1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation') 5 □ Other (Specify)		-	-		/2005	Baltimore	e. Maryland
	Departm Departm Importal any inju		21. Signature of Juneary Service Licensee						Funeral Ho	
١ ۵	88 5 8						-		re, MD 212	
			23a. Part1. Ezer the alse ase, or complications that cause shock. The a raise ase, or complications that cause shock.	d the death. D	o not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	hysician /Medical		Immediat Cause Final disease or condition resulting in death)	2 3 U	bdu	101	Hemo	rtow.	or mind	5 Days
	Examiner		Due to (or as	a consequenc	ce of):				Deli	
	NE S	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	а попведнело	na al):			00	701	
	n and ial-transit	Examin	Cause (Disease or injury that initiated events c.					2000	1 0	
	ia exe ian a urial-t	_	resulting in death) Last Due to (or as	a consequent	ce of):		200	N. X	,;;,`	
	The law requires that the geant centificate be executed attending physician and bage 2 should be detached for use as the burial-transit	dlcal	d				- William	A Maria	L'ixon	
٠ ×	iding p	ician/Med	IF FEMALE: 23c. If yes, outcome	of pregnancy			1	7/\:	23d. Date of d	
ם ז	atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant a			Ectopic pregnanc Other (specify)	y /	Si.	Month	Day Year
	by the	hysi	9 Unknown							
'n	sician: The law requires that the death cer certificate has been signed by the attendin rector, page 2 should be detached for use	by Physic	Part II. Other significant conditions contributing to death to	out not resulting	g in the u	nderlying cause gr	ven in Pa /I.			to the cause of death?
COI US,	aen si	ted						10	Yes 2 No 3	Probably 4 Unknown
ט -	has b	ompleted						24a. Was		autopsy findings available o completion of cause of
		O						1 Yes	2□No 1/2 Y	
X	certif	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 No Hospital: 1 Inpati		/Outpatier	nt 3□ DOA Ott	200	ith (Check only o	dence 6 Other (S	nacifu)
5 8	grnys er this eral dii	H	27. Vanner of Death 28a. Date of Injury	ury 28t	b. Time o		ry at		how injury occurred	occupy,
5	ath. or: After ne funer	Certification:	2 Accident investigation Fe BRUM	24 26,200	5 Ol		Yes 2 No	FAL		
2	ter de irecto	tifle	3 Suicide 6 Could not be determined 28e. Place of In building, e	tc. (Specify) ,	1	reet, factory, office		City or To	Street and Number or wn, State)	
ב כ	To the nospital or Attending Priystcian: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		- E			ITAL			PANKLIN SQL	7 17
	24 ho	Medical	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis one) and manner si	of examination						
	o the vithin o the comple	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mo	nth, Day, Year)
,	->-0		1 (1/AZ			Do	0623	373	February	27,2005
	1		30. Name and address of person who completed cause of	death (Item 23	Ba) (Type,	Pnnt)				1 - 1 - 0
	10		Dr. Robert Paz, 9000 Fro	nklin	Squ	are Dri	ve Bai	timore	mD	21221
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	Es.	1.4.				
DHM	H 17 Rev 1/2	-	MAR 0 3 2005	Eur L	7.	parket				
. ,	1.04 1/6									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2^{Day} 2005^{ear} **Physician** Harley 4:30p. M Isaiah /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Garden N.H. Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) **Funeral** Months Days **X**M 2□ F Hours ountry M D 217-24-4612 74 Yrs 6-27-30 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If them 27 is marked other then "naturel", or iteme 23a or 28a-f show any injury or other treumatic event, It a Maritial Examination and Examination 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County 1 ☑ Yes 2 ☐ No MD NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4700 Harford Road U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: 3 ☐ Widowed 4 🎖 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Various Jobs 8th grade na 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Essie Staley ပ Oscar Harley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3014 Ferndale Ave, Baltimore, Md 2120 ce of Disposition (Name of Date 20c. Location - City or Town, State Oscar S. Harley-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 3/7/05 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 als 4300 Wabash Ave. March F.H. West 23a-Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4-Nursing Home 5 - Residence 6 - Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Alatural 5 Pending 1 Tes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitei within 24 hours a To the Funerel D 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cedifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 ver Neck MUDOMIT 201-109 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

DHMH 17 Rev 1/2001

[1- For Unpend Item 23	State of Maryland & D	epartment of Health and Certificate of Death	Mental Hygi	ene 005 07088
	0	ret.	Decedent's Name (First, Middle, Last)			2. Date of Death	3 Time of Death
	Physici		Janet A.	Hannan		FEBRUARY	7.55 A M
>	/Medic Examir		4a. Facility Name (If not institution, give s 4 PERHALL COURT		4b. City, Town, or Location of Dea		4c. County of Death BALTIMORE CO
	Funeral Director		213-40-3788	7. Age (In yrs. last birth	Months Days Hours Min		Year) 9. Birthplace (State or Foreign Country) Maryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	the Maryt 28a-f sho	Director	Maryland Baltim 10e. Street and Number	ore	Nottingham	10	1 ☐ Yes 2 ☑ No
	with		4 Perhall Ct.			10	g. Citizen of What Country?
	leath	era		12. Was Decedent Ever in U.S.	21236	Specify Yes or No-	U. S. A. 14. Race - American Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 show other traumatic svent, I're Madical Executes Trust be rollified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☼ No Specify:	to Rican, etc.)	Black, White, etc. Specify: White
5-0	72 ho	Completed	15. Decedent's Edu- (Specify only highest grade	cation 16a. D	Decedent's Usual Occupation Give kind of work done during most of wo	ndking 1	6b. Kind of Business/Industry
21	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		Blue Cross &
	ould be filed with Mental Hygiene. arked other than atic svent, Inc.	S	47 Fabrus Norma (Fina Middle Land)	4 Years	Registered Nurse		Blue Shield
and	be fi htal H ed otl	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, M.	
ž	should Ind Men	2	Howard L. Weller	na Deint) 10h I		yn E. Por	
Maryland	d 2 sho th and 7 is ma traum	1 8	19a. Informant's Name/Relationship (Ty		Mailing Address (Street and Number or R		
	1 and 2 Health tem 27		Michael T. Hannar 20a. Method of Disposition	20b. Place of E	Perhall Ct. Nottin	Date Mar	ULANA 21236 Oc. Location - City or Town, State
<u>0</u>	Pages nent of I int: if it		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cemetery,	crematory or other place)		
Baltimore,		10	21. Signature of Truneral Service License		ood Cemetery 3/03	/2005 5	altimore, Maryland
Ba	permit. Departn Imports any inju		Chun Be		22. Name and Address of Facility Sc 3331 Brehms Lane,	humunek t Raltimata	uneral Home Inc.
			23a Part1. Enter the disease, or compli	cations that caused the death. Do no	t enter the mode of dying, such as cardia		St. Approximate
	Pnysician		shock, or heart failure. List only or Immediate Cause (Final				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Cardiac Arrhythmi Due to (or as a consequence of			
	Examiner		Conventiolly list conditions				
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				il in the second
,092	e execian a	ñ	resulting in death) cast	Due to (or as a consequence of):		
687	cate b	dlcal					
.O. Box 6	The law requires that the death centificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	GC. If yes, outcome of pregnancy 1	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Records, P.	signed by		Part II. Other significant conditions con	tributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
Sor	w requir been si should	lete				24a. Was an	24b. Were autopsy findings available
al Re		Completed by				autopsy performe 1 Yes 2	prior to completion of cause of death? No 1 X Yes 2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1X Yes 2 □ No	ospital:	Other	ath (Check only one)	
of			27. Manner of Death	28a. Date of Injury 28b. Tir	atient 3 DOA 4 Nursing r	lome 5 Residen 28d. Describe how	TET TOOLITE
on	ding f th. : After funer	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inji			,.,
Division	is or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Cartifying Phys (Check only one) 2 Madical Examir	ician: To the best of my knowledge, ther: On the basis of examination and/and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occurred.	a, and due to the cau urred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifier		29c. License number	290	1. Date signed (Month, Day, Year)
			> Talmill	las Ali-	OCME	I	FEBRUARY 27, 2005
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Tr	ype, Print) 111 Penn Street	: Baltim	ore, Maryland 21201
•	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Actor		
	Registr	ar	MAR 0 3 20	05 8.	Last a		

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For Stete Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygien	~000 0/089
Physic /Med Exami	ical	1. Decedent's Name (First, Middle, Las HARLE 4a Facility Name (If not institution, give	S HENRY A	4b. City, Town or Location of Dea	2. Date of Death Month MARCH	2005 3. Time of Death 1 2005 1 10 AM
Funeral Director		5. Social Security Number 6. Second Security Number 7. Second Security Number 11. Usual Residence of Decedent	N 1708 P11111 ex 7. Age (In yrs. lagt birthda) IM 2□ F 74 Yrs.	() If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign 130 NORTH CARVUNI
the Maryland 28a-f show	Director	10a. State 10b. County	10c. City, Town or L	TIMORE		10d. Inside City Limits 1
-0036 hours after death with the Maryland turel; or lieme 23e or 28a-1 show a Examinat must be notified at	Funeral Dir	10e. Street and Number 2/04 SOUTHE. 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ✓ Yes 2 □ No	10f. Zip Code 2/2/4 . Was Decedent of Hispanic Origin? (stift Yes, specify Curban, Mexican, Puer		itizen of What Country? 14. Race - American Indian, Black, White, etc.
21215-0036 de within 72 hours afl giene. er than "naturel; or the Malc. Exercise.	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grad Elementary/Sector day (0-12)	College (1-4or 5+) (Giv.	1 ☐ Yes 2 ☐ No Specify: edent's Usual Occupation 9 kind of work done during most of wo DO NOT use retired)	rking	Specify: BLACK Kind of Business/Industry NOUSTRIAL
tnd be file stal Hy od oth	To Be Cor	17. Father's Name (First, Middla-Last) MORKIS IA	ILOR	ELIZ	me (First, Middle, Maide LABETH	HOWELL
or Heal		19a. Informant's Name/Relationship 77. ERACOINE HOW 20a. Met/lod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	VELL /WIFE 210	ematory or other place)	Date 20c. I	NORE MD 2/2/4 Location - City or Town, State
Baltimore, permit. Pages 1 a Department of Hei Importent: If item any injury or othe		*4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens Wawfur	PARK We	905 YORK KOAD	BATIMORE	CTIMORE, MARYLAND REENE TONERAL HUM MARYLAND 21212
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. CEREBRON Due to (or as a consequence of):		ACCIDE	Approximate Interval Between Onset and Death
icate be executed Experiment by sician and surial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of): c. — Due to (or as a consequence of):			
Geath certification of the designation of the desig	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
I Records, P.O The law requires that the atte has been signed by the page 2 should be detache	b		ntributing to death but not resulting in the U		10.0	use contribute to the cause of death?
Division of Vital Records, if or Attending Physician: The law requires that death. Director: Atter this certificate has been signed in by the funeral director, page 2 should be	Completed	HY PERLI PI DEM	111 CHRONIC	RENAL FALL	autopsy performed? 1 Tes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
f Vit	To Be	examiner?	Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatien	04	th (Check only one) ome 5 Residence	6 □Other (Specify)
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification completely filled in by the funeral director.	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inju	ry occurred
Division To the Hospital or Attentwithin 24 hours after dealt To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At home, farm, sti building, etc. (Specify)		City or Town, State	
ne Hos n 24 ho ne Fun pletely	Medical	(Check only 2 Medical Exami	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	in occurred at the time, date and place exestigation, in my opinion, death occu	, and due to the cause(s rred at the time, date an) and manner as stated. d place, and due to the cause(s)
To the I within 2 To the I complet	ž	29b. Signature and title of certifier	intar MD	29c. License number RES 000	į	tte signed (Month, Day, Year)
		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type,	Print) OCH RAVEN BL	VD BALTI	MORE, MD 21239
Sta		31. Date filed (Month, Day, Year)	32 degistrar's Signature			

amend item#26, perMy C841 3/3/05 State of Maryland / Department of Health and Mental Hygiene O O S 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 27, 3. Time of Death February **Physician** Harry N. Hagy, Sr. 2005 9:57 A. M /Medical 4a_Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 🖟 M 2 🗆 F 219-20-5561 Director April 11,1927 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits N/A Baltimore Maryland 1 Yes 2 No Director 10f. Zip Code 21209 10e Street and Number 10g. Citizen of What Country? 1304 Appleby Avenue USA death Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Depertment of Health and Mental Hygiene Important: If Item 27 Is marked other than "natural, or Item any injury or other traumatic event. Its Medical Evanded 1 X Yes 2 □ No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry B and O Elementary/Secondary (0-12) College (1-4or 5+) Yard Foreman Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hagy Norman Chenworth Mary 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1304 Appleby Avenue Baltimore, Maryland 21209 19a. Informant's Name/Relationship (Type, Print) Dorothy Hagy Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 3/2/2005 Pikesville, Maryland 21. Signatur of uneral Service Licenses ^{22. Name and Address of Facility}
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYDCArdia in traveton 10 minutes /Medical Due to (or as a consequence of): **Examiner** CONDMANN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit certificate be exect Due to (or as a consequence of): P.O. Box 68760 by the attending physician Physician/Medical IF FEMALE ns_e 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ō in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 I Inknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home Members 6 Other (Specify) 2 1 🔲 Inpatient 2X ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAR 01,2005 AVE? s of person who completed cause of death (Item 23a) (Type, Print) ROBSET Turen ms osion on Sure 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar MAR 03 2005

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylar	•	artment rtificate		ealth and N	Mental Hyg	giene	E 07001
			Registrar 1. Decedent's Name (First, Middle, Las	<i>+</i>)		Cei	rincate	9 01 6	Jeam	2. Date of Dea	leg. No.C. UU	0 0/091
	Physicia	an	Walter Morri		Hawa	Tax				Month	Day Ye	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give		Hare,	UL.	4h City 1	Town or	Location of Death	Februar	cy 24, 20 4c. County of E	
	Examin	er					40. Oity, 1					
	Funeral		Greater Baltimon 5. Social Security Number 6. Se			lter . last birthday)			WSON If Under 24 Hrs.	8. Date of Birtl (Month, Day	Baltim	
	Director			∑ M 2□F	8	Yre	Months	Days	Hours Min.		9, 1924 M	Birthplace (State or Foreign Country)
			Usual Residence of Decedent							White I	9, 1924 N	ary rand
	arylar	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-1 show r must be netflied at	Director	Maryland Harford		E	dgewood	E					1 ☐ Yes 2√ No
	or 2	E E	10e. Street and Number				10f. Zip	Code			l0g. Citizen of Wha	t Country?
	ath v 23a	ā	3416 Lansdowne Co					040			USA	<u>-</u>
\	er de	une	11. Marital Status	12. Was Deced	es?	J.S. 13.	Was Decede If Yes, speci	ent of Hi ify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
36	rs aft	by Funerai	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 t∏Yes 2 If Yes, Give Year or Dat			1 ☐ Yes 2	No ₹	Specify:		Specify:	
3 5	ture fure	edt	15. Decedent's Ed		www.	II lea Decer	dent's Usual	I Occupa	ation		16b. Kind of Busine	White
子55	nin 72	plet	(Specify only highest grad	de completed)	45-1	(Give		k done o	luring most of work	ring	TOD. TAILE OF DESITE	ssamuusti y
21215-0036	d with	Completed	Elementary/Secondary (0-12) Q	College (1-	+01 5+)	Load	ler				Steel Ma	nufacturing
	al Hyg othe	Be C	17. Father's Name (First, Middle, Last)				41		18. Mother's Nam	e (First, Middle,	Maiden Sumame)	nuracturing
\preceq is	uld b Venta rrked tice	To E	Walter Morris	on Ha	are, S	r.			Agnes	(u/k)	Koyne	
Maryland	sho and h	7	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a	nd Number or Rui		r, City or Town, Stat	
(V)	and 3 ealth n 27 eer tr		Katherine H. Hare	- Wife						Edgewood	d, Maryla	nd 21040
more	of H if iten		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from St	20b.	Place of Dispo cemetery, cren	sition (Name natory or oth	e of her place	9)	Date	20c. Location - City	or Town, State
Ø.	Pag ment tent: jury c		`4 ☐Donation 5 ☐ Other (Specify			ownsvil	le Ve	t. (cem. 3-03	- 05	Crownsvil	le, Maryland
新	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturet", or items 23a or 28a-f show any injury or other treumetic event, It's Medical Examiner must be neitified at one.		21. Signature of Funeral Service Licen:	500			. Name and		SE 2000	McComas	Funeral :	Home, P.A.
- 8	00 = 4 O		sylle (14)	wery								yland 21009
-			23a. Part1. If ter the disease, or comp shock, or heart failure. List only	olications that cau	used the dea ch line.	th. Do not ent	er the mode	of dying	, such as cardiac	or respiratory arr	est,	Approximate Interval Between
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0	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0)	as a consec		OPD					Years
٧	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	c Due to (or	r as a consec		- 1 20					
760	bu bu	ical E		d								•
~	ificate g phys as the		-	·								
ŏ	ath certifica attending ph for use as t	<u>N</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregn		3e				23d. Date of	delivery
œ.	ne deati the atte	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnar	nt at time of o		Ectopic pre Other (spe				Month	Day Year
Ö.	Attending Physicien: The law requires that the death certifica r death. sctor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the funeral director.	Completed by Physician/Med	9 🗆 Unknown	9□ Unknow								
s,	uires thai signed b d be det	by	Part II. Other significant conditions co	(th but not res	sulting in the ur	nderlying ca	use give	n in Part I.	23e. Did tol	pacco use contribut	e to the cause of death?
ord	w requir been si should	ted	Dws	King	<u></u>					1 🗆 Ye	es 2 □ No 3 □	Probably 4 □Unknown
ec	e lawr has be ge 2 sh	ple		0						24a. Was a	n 24b. Were	autopsy findings available
<u> </u>	ysicien: The is certificate hidirector, page	50								perform	ned? death	to completion of cause of 1? /es 22 No
/ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						26. Place of Deat	n (Check only on	e)	
Ž	Physic this corral dire	2	1 □ Yes 2 No			ER/Outpatien			4 U Nursing Ho	me 5 Reside	ence 6 Other (S	Specify)
ם	ding P th. After t funera	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		c. Injury Work		28d. Describe ho	w injury occurred	
Sio	tend Jeath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be				М		'es 2 □No			
Division of Vital Records, P.O. Box 6	or All	Certification:	4 Homicide determined	286. Place of	i Injury - At h j, etc. <i>(Speci</i> i	ome, farm, stre fy)	eet, factory,	office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
	pitel ours a	2	29a. Certifier 1 Certifying Phy	reicien: To the b	ant of my kno	ovelodao doath	o o o o urrad a	t the time	o data and place	and due to the e		
	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: At completely filled in by the fun	Medical	(Check only 2 Medical Exam	iner: On the bas	is of examina	ation and/or inv	estigation, i	n my op	inion, death occurr	ed at the time, d	ate and place, and o	due to the cause(s)
	ro th within ro th	Me	29b. Signature and title of certifier			1	29c.	License	number	2	9d. Date signed (Mo	onth, Day, Year)
			1/2/20	_ w	> «	iptt	DO	00 E	0460		2/25/	05
x\			30. Name and address of person who c			m 23a) (Type, I	Print) G	ary	Chiang,	MD	i (
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*	Stat		31. Date filed (Month, Day, Year)		jistrar's Signa	ature	and a					

			1 - For State Registrar	State of M	aryland		artmen rtificat				F	leg. No	005	07092
п	Physici	an	Decedent's Name (First, Middle, La.	st)							Date of Dea Month	Day	Year	3. Time of Death
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	Examir	ıer	PRESBYTERIAN HOM		,		4b. City,	Tows		DiDeath		1	ounty of Deat	
	Funeral		5. Social Security Number 6. S	ex 7. A	ige (in yrs. las	it birthday)	If Under	1 Year	If Under		3. Date of Birth	1		hplace (State or Foreign
	Director		213-05-8439	□M 2□F	87	Yrs.	Months	Days	Hours	Min.	(Month, Day May 3.	, year) 1917		ryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	ocation							10d. Inside City Limits
	Maryl.	ō		Carrata										1 ☐ Yes 2 No
	r 28a	Director	Maryland Baltimo	ore County	y	10	OWSON 10f. Zip	Code			1	0g. Citize	n of What Co	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ta Modical Extribitor and but halified at		400 Georgia Cour	:t					21204				USA	
	r dea	Funerai	11. Marital Status	12. Was Deceden Armed Forces		13.	Was Deced	dent of Hi	ispanic Orig	gin? (Speci	fy Yes or No- can, etc.)	14	Race - Ame Black, White	
36	s afte	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 € If Yes, Give X	No		1 □ Yes		Specify:		, , , , ,	S	necify:	
21215-0036	72 hours "natural", Jical Ext	edt	15. Decedent's Ed	Year or Dates:		16a. Dece	dent's Usua	A Occupa	ation	-		16b Kind	WIT of Business/	ite
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nd		Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name (First, Middle,	Maiden Si	umame)	
Maryland	d 2 should be the and Menta 7 is marked traumatic even	2	John Thomas S	Spellman		105 14-15		(0)		1en			Mills	
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Baltimore,	permit. Pag Department Important: I any injury o	Ì	21. Signature F in my Service Rear	000	Mest	22	Name an	d Addres	s of Facility	5/1/2	Funera.	Jai	ESVIII	e, Mary Land
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			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that cause one cause on each	ed the death. line.	Do not ent	er the mod	e of dying	g, such as	cardiac or r	espiratory arr	est,	.y Land	Interval Between
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l,		her	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequer	nce of):								
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э х 6	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome	e of pregnanc	v						220	d. Date of deliv	
Вох	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1☐Live birth 4☐Pregnant a	2 Fetal de	ath 3	Ectopic pro Other (spe					230	Month	Day Year
P.O.	that the deby the detached	hys	9 Unknown	9□ Unknown										
	se ug	by P	Part II. Other significant conditions of)	but not resulti	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
ord	v requir been si should	ted	Chronic asi	hma						- 1	1 🗆 Ye	s 2 21	No 3 ☐ Pro	bably 4 Unknown
Records,	has b	Completed			-						24a. Was a autops	ý	prior to co	opsy findings available ompletion of cause of
	T ate											No No	death?	2⊠ No
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	0 T E	VOutpatien		Othe			Check only on		70.1	
		\vdash	27. Manner of Death	28a. Date of Inju	ury 28	b. Time of		Bc. Injury	at		5 Reside			ity)
Ö	Attending I r death. ector: After by the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay rear)	Injury	М	Work	es 2□N	10				
Division	II or Attend after death Director: /	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At home	, farm, str	et, factory	office		281	Location (Sti	reet and N , State)	lumber or Rui	ral Route Number,
	Hospital or 14 hours afte Funeral Dir tely filled in t									1				
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best inar: On the basis of and manner st	of examination	dge, death and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deatl	d place, and h occurred	d due to the ca at the time, da	use(s) an ite and pla	d manner as : ace, and due !	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	and mainter si	tated.		29c.	License	number		29	d. Date s	igned (Month,	Day, Year)
}	->-0		· n_	Atte.	ading	am		03	3701	6		Fesn	acry 2	25, 2005
	_		30. Name and address of person who	completed cause of	death (Item 23	Ba) (Type,	Print)						. J	
	3		Kenneth M. Greet	ne. M.D.	6701 1	Vorth	Char	100	Stree	t. То	พรดา	Marti	l and 91	20/1
	Sta Registr	16	31. Date filed (Month, Pay, Year) 3 2	005 32. Tegisti	rar's Signatur		alle			, 10	wson,	LILL Y	Lana 21	-204
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician February 26 ް005 Sylvester Hopkins Sr. 2220 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Sept 5 9. Birthplace (State or Foreign **Funeral** ^Y27945 218-42-5451 M 2 □ F 59 Yrs. Marvland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Maryland Anne Arundel Harwood Director 1 ☐ Yes 2 N No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 4180 Sands Rd. 20776 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Itel Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Patuxent Material Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 INC. Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel L. Hopkins Lillian Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traum once. Barbara Hopkins(Wife) 4180 Sands Rd. Harwood, Md. 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State Moses Cemetery 3-5-05 Drury, Md. ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. Lavry B. Leese Mc0 /8 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit certificate be executed Due to (or as a c insequence of) attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ρ Month Day Year 4 Pregnant at time of death P.O. 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by The law requires pe 1 Yes 2 No 3 Probably 4 thenknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No page certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician; 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 hpatient ۴ 1 🗌 Yes 2 ER/Outpatient this 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner if Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) To the the 29b. Signatura nd title of Califier 29c. License number 2 29d. Date signed (Month, Day, Year) mi 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (tr. thire Arundel NHAICAI Davi 31. Date filed (Month, Day, Year) 32. Resistrar's Signature 0 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Maryland	/ Depa		of He	ealth and	-	_	05 07094
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) Vivginia I 4a. Facility Name (If not institution, give si			4b. City, T	own, or l	Location of Dea	2. Date of D Month 2	Day 26 4c. Count	Year 3. Time of Death Year 1-45 M y of Death
	Funeral Director		Usual Residence of Decedent	7. Age (In yrs. last M 212 F 55	Yrs.	If Under 1 Months		If Under 24 Hr Hours Mir	. (Month, D	N/A irth lay, Year) 9,1949	9. Birthplace (State or Foreign Country) New York
	with the Marylar a or 28a-f show Le notified at	Funeral Director	Maryland Maryland 10e. Street and Number 2806 Plainfield	imore 10c. City, To	own or Lo	10f. Zip (Code	21222	I	_	10d. Inside City Limits 1 □ Yes XXNo What Country? L States
920	be filed within 72 hours after death with the Maryland that Hygiene. Ind other than "natural", or Itams 23a or 28a-f show event, the Modical Examination at the motified at	þ		2. Was Decedent Ever in U.S. Armed Forces? 1		Was Decede f Yes, speci 1 Yes 2			Specify Yes or N rto Rican, etc.)	o- 14. Ra	ce - American Indian, ack, White, etc.
121215-0036	ied within 72 ho lygiene. her than "natur it, ine M. dical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12. Years	ation 16 completed) College (1-4or 5+)	(Give life. L	dent's Usual kind of work DO NOT use gal A	done du retired) SSIS	iring most of w tant		Leg	Business/Industry
Maryland	2 should be and Mental Is marked o	To Be	17. Father's Name (First, Middle, Last) Ralph Eicher 19a. Informant's Name/Relationship (Typ				Street ar	nd Number or F	lural Route Numb	Goldfuss Der, City or Town	, State, Zip Code)
ຜົ	permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or othar tra once.		Leigh-Ann Isenocl 20a. Method of Disposition 1 Burial 2 Cermation 3 Re 4 Donation 5 Other (Specify) 21. Signate of Funeral Service Licenses	emoval from State 20b. Place ceme	of Dispontery, crem	sition (Name natory or oth Servi . Name and	e of per place, CE C	orp. 3/	Date	20c. Location	yland 21222 City or Town, State on, Maryland k. Inc.
760,	(e be executed // Medical Examiner Medical e purial-transit	cal Examiner	23a Part 1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Α	co not enter	922 Wiser the mode	se A of dying,	such as cardia	indalk,	Maryland	Approximate Interval Between Onset and Death
O. Box 68	The law requires that the death certificate tte has been signed by the attending phys age 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pred Other <i>(spec</i>					ate of delivery onth Day Year
Records, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions cont	ributing to death but not resulting	g in the un	iderlying cau	ise given	in Part I.			tribute to the cause of death? 3 ☐ Probably 4 图Unknown
Vital Rec		e Completed	25. Was case referred to medical					26. Place of De	24a. Was auto perfo	psy ormed? 28 No	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
of	ding Phys n. After this funeral dii	Certification; To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	. Time of Injury	M 286	Other: C. Injury a Work? 1 Ye	4 ☐ Nursing I	Home 5 ☐ Resi		
=	o lifte		4 Homicide determined 29a. Certifier 1 Certifying Physic	28e. Place of Injury - At home, building, etc. (Specify) cien: To the best of my knowled				, date and plac	City or To	wn, State)	per or Rural Route Number,
)	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examine 29b. Signature and title of certifier	and manner stated.	and/or inv	estigation, ii 29c.	i my opir License r	nion, death occ	urred at the time,	date and place,	and due to the cause(s) d (Month, Day, Year)
_	1		30. Name and address of person who in Am Radapate.	2434. W. Bele	ede	Print)			more.		
	Sta Registr		31. Date filed (Month, Day, Vear) MAR 0 3 2005	32. Registrar's Signature	book	()					

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of		/ Dep	artment of H	ealth and	Mental Hyg	iene 005	07095
Phys	ician	Decedent's Name (First, Middle,	,			_ ,		2. Date of Deat Month	th Day Year	3. Time of Death
	dical		Iol		S.	Jacks		2 2	27 2005	15:45 M
Exar	niner	4a. Facility Name (If not institution,	-			4b. City, Town, or		h	4c. County of Deat	h
	-	Union Memor		pital			imore			
Funer		5. Social Security Number 215-22-7144 Usual Residence of Decedent	3. Sex 7.	Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) Co	nplace (State or Foreign untry) MD
yland		10a. State 10b. County		10c. City, To	own or Lo	ocation				10d. Inside City Limits
Mar 9-fst	ţ	MD NA		Balt	imoı	e:				XIXYes 2 □ No
h the	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What Co	untry?
th will		3908 Carlisle	Ave			21	216		USA	
r dea ems	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Race - Ame	rican Indian,
or le		1 Never Married 2 Marrie				1 ☐ Yes 2 🌠 No		o rican, etc.)	Black, White	
15-UU36 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show dical Examiner must be notified at	d by	3 ☐ Widowed ★★**Divorced	Year or Date						Specify: B	lack
within 72 ho iene. r then "netur the Medical	Completed	15. Decedent's (Specify only highest	Education grade completed)	10	Sa. Dece (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation <i>Juring m</i> ost of wor	rking	16b. Kind of Business/I	ndustry
21215-0036 ad within 72 hours afl giene. ar then "natural", or in the Medical Exemi	l g	Elementary/Secondary (0-12)	College (1-4	or 5+)						
		12th grade 17. Father's Name (First, Middle, La	2yrs		вес	utician		ne (First, Middle, M	Beauty S	hop
	o Be	James Walter	Smith			Ì		ie McDar		
Maryla d 2 should the and Ment 7 is marked traumatic of	2	19a. Informant's Name/Relationship		phou 1	9b. Mailir				City or Town, State, Z	in Code)
and 2:		Charles W. Do		_					nore, Md	21216
		20a. Method of Disposition	LBEY OL.	20b. Place	of Dispo	sition (Name of	-		20c. Location - City or 1	
		1 Surial 2 ☐ Cremation 3 1 Donation 5 ☐ Other (Spe		ile .		natory or other place	.			
DEMITTING permit. Page Department of Important: If any injury or	ooi	21. Signature of Funeral Service Lice	- "	Wood		Cemete . Name and Addres		7/05 I	Baltimore	Co, Md
E Per de	S C C C C C C C C C C C C C C C C C C C	May Bo	Kok.		1	Italiib alia Adalba	M	arch F/		21215
		23a. Pari 1. Enter the disease, or co shock, or head failure. List or	omplications that caus	sed the death. D	o not ent	er the mode of dvino	Waba	sh Aven	ue Balto	Approximate
Pnysicia /Medica	_	shock, or hearthallure. List or Immediate Cause (Final disease or condition resulting in death)	a	n line. as a consequ <i>e</i> nc		remia Venal t				Interval Between Onset and Death
ate be executed Expression and the burial-transit	Ical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	as a consequenc		Cenal t	aller			
ath certific titlending p	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown		2 Fetal dea at time of death		Ectopic pregnancy Other (specify)			23d. Date of delive	rery Day Year
gne bed	by	Part II. Other significant conditions	s contributing to death	n but not resulting	in the ur	iderlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
w requir s been si	olete	T	Simbetter					24a. Was an	246. Were aut	opsy findings available
The The ate h	e Completed	25. Was case referred to medical					00 Bloom 4 Brown		ed? prior to co death? 1 Yes	ompletion of cause of
Physician: r this certific ral director,	0 0	examiner? 1 [] Yes 2 [] No	Hospital:	atient 2 ER/C	Outnation	Otho		th (Check only one	nce 6 Other (Speci	4.1
Jing After funer	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of It (Month, I		. Time of Injury	28c. Injury Work		28d. Describe how		(9)
LIVISION tal or Attending rs after death. al Diractor: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of	Injury - At home, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	of examination a	ge, death and/or inv	estigation, in my opi	nion, death occur	and due to the car red at the time, da	use(s) and manner as s te and place, and due t	stated. o the cause(s)
Vitt To Con	5	29b. Signature and title of certifie	1	40		29c. License		29	d. Date signed (Month,	Day, Year)
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3		30. Name and doors of person wh	Althe	man) (Type, i			Tree	Rel	U208
Regis	tate trar	31. Date filed (Month, Day, Year) MAR 0 3 20(RJ .	strar's Signature	door	les		-		

State of Maryland / Department of Health and Mental Hygien 0 0 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OO TM Mildred H. Juliano February 2005 27. -/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Brighton Gardens Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplece (State or Foreign Country) Months Days Hours 1 □ M Yrs. Director 288-09-7070 Sept 20,1910 Indiana Usual Residence of Deceden filed within 72 hours after death with the Maryland 10a State wode 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or Items 23a or 28a-f ehov the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 ☐ No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6451 N. Charles Street Suite 204 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed by Specify: 3 X Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) pes 1 and 2 should be filed w of Health and Mental Hygier If item 27 le marked other th or other traumatic event, the Market Researcher Elrick & Lavidge 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ George Α. Smith Wycoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana J. Emerson daughter 2 Selsed Garth; Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 X Burial /2 Cremation 3 Removal from State = 5 permit. Page Department of Importent: If any injury or once. 4 □ Donation | 5 □ Other (Specify) 3/4/05 Oaklawn Mem Gardens Indianapolis, IN 21. Signature ou Funeral Service Lice 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 15 kideor defice disease or condition resulting in death) Swarpy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last reamsone Examiner to (or as a consequence of). or Attending Physicien: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as - cons - uence o Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2□ No 1 ☐ Yes 2 ☐ 1/0 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 2 ☐ 16 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral s after death. 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospite! 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type Print) 30. Name and address of person 10755 31. Date filed (Month, Day, State Registrar

Amend Item#20b, per Fift G841 3/08/05 CC State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Evelyn Jones 40 PM February 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Memorial Hospital Baltimore NA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Md. **Funeral** Months 1 ☐ M 2 💢 F Director Yrs 85 214-18-5986 Usual Residence of Decedent the Maryland 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 □ No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2011 Homewood Ave. 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Heatth and Mental Hygiene. Int: If item 27 ia marked other than "natural", or iter Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: Black 3 ₩Widowed 4 Divorced Completed traumatic event, If e Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Other People Homes 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Gray 2 Georgia Vincent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t Health item 27 i Robert R. Jones 9705 Tulsemere Rd., Randallstown, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. 1

Burial 2 □ Cremation 3 □ Removal from State Arbutus Mem. Park Arbutus , Md. 3-5-05 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 04 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cardiamyopathy disease or condition resulting in death) Ischemic year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 certificate 1 🗌 Yes 2 No Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this ate finjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No after death Diractor: / 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To tha Funeral I Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1005239 ens m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Medicine Union Memorial Hospital Department 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 03 2005 Registrar

05-01464 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. THEODORE M JACKSON WHM Unpend Item 23a,27,28a-f per me 6841.3-18-05 tas

Reg. No. 1 - For U Stete Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 25, 2005 lackson **Physician** 9:36 P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 464 MANSE COURT BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Quintry) 5. Social Security Number **Funeral** 1**2** M 2□ F 7-86-7111 Yrs. ma Director Usual Residence of Decedent 10d. Inside City Limits Marylend 10b. County 10c. City, Town or Location 10a. State or than "natural", or items 23a or 28a-f show the Madical Everity at mast be notified at 1 XYes 2 □ No Directo Mary and Number more 10f. Zip Code 10g. Citizen of What Country? 464 21 20 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 X No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busines Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed withln 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 20re traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Se Keyser heodore phine 19b. Mailing Address (Street and Number or Rur Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (mother) 20b. Place of Disposition (Name of cometery, crematory or other place) Manse Department of Health a Important: if item 27 is any injury or other tra 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 22. Name and Arress of Facility 21. Signature of Funeral Service Licenses tuneral Homed. 21216 W. Porth 23a. Plan 1. Enter the insease, or complications that all uses the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or hearth littre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Narcotic intoxication and Cocaine Use /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Cher (specify) P.O. | ed by the a 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ sign d be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death.

1 ☐ Yes 2 ☐ No 1∐Yes 2□ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 1 XYes 2 No Found, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death unk Found 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2-25-05 2 Accident after death Director: In by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 464 Manse Ct. 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours after Eunerel Dire letely filled in b Found at home Baltimore, Md 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely

State

within 2 To the To the

> MARYBANDS 31. Date filed (Month, Day, Year)

More

29b. Signature and title of certifier

(Check only one)



ne Name and address o person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Khill



29c. License number

111 Penn Street

OCME

29d. Date signed (Month, Day, Year)

FEBRUARY 26, 2005

Baltimore, Maryland 21201

			For Stete Registrar	State of Maryland / D	Department of H		ental Hygien Reg. ฟ	Z11115	07099
	Physici /Medic		1. Decedent's Name (First, Middle, Las	"King		-	4	ay Year 27200	3. Time of Death $2:50^{\text{PM}}$
	Examir		4a. Facility Name (If not institution, give St. Agnes Hea	street and number) IHCQTE	4b. City, Town, o Balt	r Location of Death	4	c. County of Death	NA
	Funeral Director		5. Social Security Number 213-14-0034 Usual Residence of Decedent	Au	hday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	3. Date of Birth (Month, Day, Year 11 - 20 - 1	O Min	nplace (Statelor Foreign untry) nnesota
	Maryland	ō	10a. State 10b. County	NA 10c. City, Town	1	more			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	72 hours after death with the Maryland netural', or items 23a or 28a-f show iteal Examiner must be natified at	Funeral Director	10e. Street and Number	A. Vanua	10f. Zip Code	21217	10g. C	Citizen of What Cou	untry?
	ter death items 2: Instrum	-unera	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Amer Black, White	
-0036	Phours af	b	3 Widowed 4 Divorced	f Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Decedent's Usual Occup	Specify:	16b.	Specify: 6	ACK
21215-0036	within ene. than "	Completed	(Specify only highest grade	College (1-4or 5+)	(Give kind of work done of life DO NOT use retired HOSTOR	during most of working d)		Ministr	ZU
Maryland	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Ernest Oles			18. Mother's Name (First, Middle, Maide	n Sumame)	(unknown)
Mary	s t and 2 should f Health and Men item 27 is marke other traumatic	1	9a. Informant's Name/Aelationship (7 Kev.Ella M.Gair	ype, Print) 19b.	Mailing Address (Street	and Number or Rural	Route Number, City + Balty	10.	
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 Disposition 4 Donation 5 Other (Specify	J 20b. Place of cemetery	Disposition (Name of y, crematory or other place	3-18-		Location - City or T	Fown, State
Balti	permit. Pag Department Importent: i any injury o		21. Signature of Funeral Service Licent		22. Name and Addre		And Gre	Stour.	moziliss
ال	Pnysician		23a. Part1. Enter the disease, or comp shock, or head failure. List only of Immediate Cause (Final	lications that caused the death. Do none cause on each line.	10	ng, such as cardiac or	respiratory arrest,	7	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a construence of		opather			UN Know
	uted d ansit	Examiner	Sequenticity list out flions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of	stive he	at Fai	lure		UNKnacen
8760,	death certificate be executed e attending physician and id for use as the burial-transit		resulting in death) Last	Due to (or as a consect once of	of):				
Box 68	leath certificate attending phys	n/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	2 Setonic organismo.			23d. Date of deliv	very
O.	that the death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
rds, P.	w requires that been signed I should be det	g.	Part II. Other significant conditions co	ontributing to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did tobacco		the cause of death?
of Vital Records,	The law requires ate has been sign page 2 should be	Complete					24a. Was an autopsy performed?	prior to co	copsy findings available completion of cause of
Vital	certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital:	Oth	26. Place of Death (Check only one)		
on of	Phys raldi	lon; To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b. T (Month, Day Year) In	ime of 28c. Injury	er: 4 ☐ Nursing Home y at 28 k? Yes 2 ☐ No	 5 ☐ Residence d. Describe how inju 		ify)
Division	ten featl tor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				f. Location (Street a City or Town, Stat		ral Route Number,
	Hospite 4 hours Funerel ely filled	edical Ce		ysician: To the best of my knowledge, liner: On the basis of examination and and manner stated.					
.	To the I	Me	29b. Signature and title of certifier	11/11	29c. Licens			ate signed (Month)	
Ţ,	1		1115 10	completed cause of death (Item 23a) (Type, Print) U maidlin	diazi	lane E	Bec 21.	229
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day. Birthplace (State or Foreign Country)
 NJ 7. Age (In yrs. last birthday) 9.4.1929 **Funeral** Months Hours Min 1₩ M 2□ F Yrs. Director 75 Usual Residence of Decedent 10c. City, Town or Location 10h County 10d, Inside City Limits 10a State itam 27 is marked other than "natural", or itams 23s or 28e-f show other traumatic event, the Modical Experiment rust be notified at 1 Yes 2 No Director NJ MORRIS PARSIPPANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 ALLENTOWN 07054 USA RD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☐ No Specify: 14 Race - American Indian Black, White, etc. 1 Never Married 20 Married 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PAINTING & DECORATING SELF EMPLOYED 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental WALTER J. KEYWORTH SR. IRENE PRICE 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 ALLENTOWN RD PARSIPPANY, NJ 07054 f Health i MADELINE KEYWORTH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State important: If it, any injury or o once. * 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEM 3.5.2005 EAST HANOVER NJ 21. Signature of Funeral Service (Icersee)

K. GREGORY FINK 22. Name and Address of Facility
MARYLAND MORTUARY SUPPORT MO1148 426 CRAINHWY CLEN BURNIE, MD 21061 SW r c implications that caused the death. Do not enter the mode of dying, such as shall you one cause on each ling. Approximate
Interval Between
Onset and Death
MON-MS . Enter the disease, or heart fail Immediate Luse (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by I should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. certificate Hospital or Attanding Physician: this After

with the Maryland

filed within 72 hours after death

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Be Certification; To

the filled in by

2 L No Inpatient

2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work?

Other:

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

1 🗌 Yes

27. Manne Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

1 Thatural

RES-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

STEPHEN M. CATTANED M.D., 600 N. WOLFE STREET, BALTIMORE, MD 31. Date filed (Month, Day, Year)

1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

03 2005

5 Pending

investigation

6 Could not be determined

Diractor:

within 24 hours a To the Funeral L

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Physicia /Medid Examin	al.	Clarine 4a. Facility Name (If not institution, give	e street and num		Keyser	4b. City,	Town, or	Location	of Death	Februa	ary 2	27, 2005 c. County of Dea	ath
		Union Memorial					imor	e If Under	24 Hrs.	0 D (D.		NA	
Funeral Director		213-74-3336	ex □M 2XIF	7. Age (In yrs. 46	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D 4-26-		9. Bi	rthplace (State or Fore Country) Va.
and	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Lim
the Marylan 28a-f show	ţō	Md. NA			Balti	more							1 XYes 2 □
ith the M or 28a-f	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What C	country?
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be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Itams 23a or 28a-f show avant, the Maulical Examinar must be notilliad at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 Tes If Yes, Give Year or Da	ces? 2 X] No e	1	Was Dece f Yes, spe I ☐ Yes	cify Cuba	spanic Or n, Mexica Specify:	n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh Specify: E	
72 hours natural',		15. Decedent's E			16a. Deced	ient's Usu	al Occupa	ation	t of worki	ina	16b.	Kind of Busines:	s/industry
d within 72 ho piene. r than "natur ne way cal	Completed	(Specify only highest grade) Elementary/Secondary (0-12) 8th grade	College (1-	-4or 5+)		nemp]		luring mos) 	i oi worki	ng		NA	
filed t Hygi othar ant, L	Be Co	17. Father's Name (First, Middle, Last,)				1		er's Name	First, Middle	e, Maide	n Surname)	
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2 sho and h Is ma auma		19a. Informant's Name/Relationship (•						or Town, State,	
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ages int of H		1 XBunal 2 Cremation 3		state	Place of Dispo cemetery, cren			Θ)				ŕ	
permit. Pages 1 Department of H Important: If ita any injury or ot		 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Licer 			lt. Car			s of Facili	3-5-			ndalk, M ce, Md.	21202
Depar Impo any ir		& lades	wa	ner		March	ı F.H	. Eas	st			North A	
cate be executed physician and the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec	,								
To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 X Unknown		irth 2 ☐ Feta ant at time of c	aldeath 3	Ectopic p						23d. Date of de Month	elivery Day Year
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To the Hospital or Attendi within 24 hours after death To the Funeral Director: / completely filled in by the fi	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	28e. Place	of Injury - At h	ome, farm, str	M eet, factor		Yes 2		28f. Location City or To	(Street a own, Sta	and Number or F te)	Rural Route Number,
To the Hospital or At within 24 hours after of To tha Funaral Diract completely filled in by	edical (29a. Certifier 1 Certifying Pl (Check only one)	nysicien: To the miner: On the ba and mann	asis of examina	owledge, deatl ation and/or in	occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the red at the time	e cause(e, date ar	s) and manner and place, and du	s stated. le to the cause(s)
To the within To the	Me	29b. Signature and title of certifier				29	c. License				29d. D	ate signed (Mor	nth, Day, Year)
		· Panet Bout	hall mo	e of death (Item	m 23a) /Tunc	Print)	OCME	;]	Febr	uary 27	, 2005
		30. Name and address of person who Pamela E. Sa			111 234) (1 y p 0 ,		11 Do	nn S		- D-1	timo	M	yland 2120

Baltimore, Maryland 21215-0036

_	_	For State Registrar	State of Ma	aryland	•	rtment of H	Death		Reg. No.	005	07102			
Physicia /Medic		1. Decedent's Name <i>(First, Middle</i> Robert	, Lasi) David	1	K	ittredge		2. Date of Dea Month FEBRUAL	Day 2	Year 3 2005	3. Time of Death 3:51 pm M			
Examine Funeral Director		4a. Facility Name (If not institution St. Mary's Ho 5. Social Security Number 215-44-5160	spital 6. Sex 7. Age	e (In yrs. las	t birthday) Yrs.	Leonar If Under 1 Year Months Days	Location of Death Cown If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Decemb	S	t. Mary' 9. Birthpl Coun. 0,1945	s lace (State or Foreign try) Jashignotn			
yland 10w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation				11	0d. Inside City Limits			
8a-fst	ector	Maryland St. M	ary's		Mec	hanicsvi	11e		10- Citi-	en of What Coun	1 ☐ Yes 2√XNo			
3a or 2	i Dir	10e. Street and Number 38415 Arlingt	on Dr.			10f. Zip Code 20659			rog. Citiz	U.S.A	•			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23a or 28a-f show any Injury or other traumatic event. Its Medical Examinar must be neilified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marriad 3 Widowed 4 Divorced	If Yes, Give			Vas Decedent of H Yes, specify Cuba ☐ Yes 2 1 No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, o Specify: Whi	etc.			
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and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relations Debra C. Kitt)	38415	Arlingt	on Drive	Mechani	csvi	11e, MD	20659			
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Physician /Medical	0.55	23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a												
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Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			. 2000A Ott	26. Place of Deat							
sin diji	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	28a. Date of Inju	iry 2	R/Outpatien 8b. Time of Injury	28c. Inju	ry at	28d. Describe l		Other (Specify occurred	ν)			
To the Hospital or Attending Pl within 24 hours after death. To the Funerel Director: After the completely filled in by the funera	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Inj	ury - At hom c. (Specify)	ne, farm, str	eet, factory, office		28f. Location (City or To		l Number or Rura	al Route Number,			
e Hospita 124 hours e Funere letely fille	Medical C	29a. Certifier (Check only one) 1 Certifyi 2 Medica	ng Physician: To the best Examiner: On the basis of and manner st	f examinatio	ledge, death on and/or in	occurred at the tivestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) a date and	and manner as si place, and due to	tated. the cause(s)			
To th withir To th comp	Me	29b oignature and title of certific				29c. Licens				signed (Month,				
1		30. Name and address of person	mo complete cause of c	death (Item 2) 23a) (Type,	Print)	14280	-		24.	-03			
			7,00	ARDTO		20650								
Sta Registr		31. Date filed (Month, Day, Year		1 Di	Coo.	de								

J 			1- For Unpend Item Registrar	State of Maryla 23a, pt. II, 27	nd / Depa per ine <i>Cer</i> i	tment of Hear		/lental Hyg	iene 005	07103
	Physici	ian	1. Decedent's Name (First, Middle, Las		,			2. Date of Dear	th _	3. Time of Death
	/Medi		Hntaine		Le	WIS		Februar		5 02:13 P.™
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or Lo			4c. County of Dea	ith
			Johns Hopkins Bayv 5. Social Security Number 16. S.			Baltimor			~/	A
27	Funeral Director	6	131 -	ox of the state o	s. last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year) C	thplace (State or Foreign ountry)
• /	/land		10a. State 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event. The Medical Exatin and injuried in 2006.	tor	md. M	A		Balt	imar	0		1X Yes 2 □ No
	th the	Director	10e. Street and Number		3 /	10f. Zip Code	17/07	1	0g. Citizen of What C	ountry?
	23a	la I	931 MCA	Leer (+	21	202		US	A
	er deg	nue	11. Marital Status	Was Decedent Ever in I Armed Forces?	U.S. 13. W	as Decedent of Hispa Yes, specify Cuban, M	nic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	rs afte	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give			pecify:	,,	Specify: j	2/00/
5-0036	tural	edt	15. Decedent's Ed	Year or Dates:	16a Decede	nt's Usual Occupation			L	JIACIC
215	hin 72	plet	(Specify only highest grade) Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give ki	nd of work done during NOT use retired)		ing	16b. Kind of Business	" / /
21	er tha	Completed	12th	N/A	nur.	sing A.	ssista	nt	FIOSP	italo
Maryland	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		Co	18.	Mother's Name	e (First, Middle, N	Maiden Surname)	
y Ja	ould Men varka	၉	bary 1	Lewis.	JR.		har	lene	AtKe	na
Mar	d 2 sh h and 7 is n		19a. Informant's Name/Rel tionship (7	ype, Print) I - daughte		1			City or Town, State,	
	1 and Healt am 2		20a. Method of Disposition		7 931 Place of Disposit		+		simd, 21	
no	ages ont of t: If it		1 Z Surial 2 ☐ Cremation 3 ☐	O 11 O	cometery, crema	tory or other place)	1		20c. Location - City or	town, state
altimore,	artme ortan injur		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen:		ing me	Name and Address of	Facility 1		and all	Funeral For
B	Depa Impo any ii		Marey m. 7	8.10.11	34	nEW. Fra	allen	St. 30	eto, mg.	7 12 2 G
			23a. Part. Enter the disease, or composhock, or heart failure. List only of	olications that caused the dea	th. Do not enter	the mode of dying, su	ich as cardiac d	or respiratory arre	est,	Approximate
	Pnysician		Immediate Cause Final disease or condition	Intracerebra	1 Hemor	rhage				Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		. nage				
- 10	Examiner	_	Sequentially list conditions,	b						
	led nsit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					
	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of);					
68760,	icate be executed physician and s the burial-transil	edical E		d						
_										
Вох	eath certif attending for use a	Physician/M	Zob. Was docodent prognant	23c. If yes, outcome of pregnation 1 Live birth 2 ☐ Feta		ctopic pregnancy			23d. Date of del	ivery
	e death the atte	sici	in the past 12 months?	4☐Pregnant at time of o		ther (specify)			Month	Day Year
P.0	that the de led by the a detached i	Phy	9 Ounknown Part II. Other significant conditions co		المراجعة الم	4.2	D			
of Vital Records,	ngi bed	d by	Cocaine Use	rithbuting to death but not 195	suiting in the undi	eriying cause given in	Ραπ Ι.		acco use contribute to s 2 □ No 3 □ Pro	10
Sor	v requi	Completed						-		
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ta		a)	25. Was case referred to medical				Division (D. 11)	1□Xxes 2	□ No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 No
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0	Attending Physician: r death. sector: After this certifics by the funeral director, k	T:uc	27. Manner of Death 1X Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe how		ary)
Siol	Attendir death. ctor: Al y the fu	atlo	2 Accident investigation	(, 52) 152,	,ary	M 1 ☐ Yes	2 🗆 No			
Division	or Ati	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif.	ome, farm, street	, factory, office	2	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	0 7 6 7	S	20a Cadiliar 1 Cadifular Bha	The state of the s						
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f	edical	29a. Certifier (Check only one) 1☐ Certifying Phy 2☑ Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death of tion and/or inves	ccurred at the time, da tigation, in my opinion	ate and place, a n, death occurre	and due to the cau ad at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
a.	To tha within 2 To the complet		29b. Signature and title of certifier			29c. License num	nber	29	d. Date signed (Month	ı, Day, Year)
			1 Carre H	allanus	ℓ	OCME			March 1,	
				ompleted cause of death (Item	n 23a) (Type, Pri		_			
			CAROL HAL	LANMA		Ill Penn	Street	Baltimo	re, Maryla	and 21201
\$? ··	Sta Registr	te ar	31. Date filed (Month Pay, Yoar) 20	05 32 Hegistrar's Signa	ature A	de)				

			1 - For State Registrar	State of	Marylan		artment rtificate			and M	ental Hy	giene Reg. No.	05	071	04
	Physicia	an	1. Decedent's Name (First, Middle					_			2. Date of Dea Month March	Day	Year	3. Time of 1:30	Death p M
	/Medic	al	Florence Rebed				4b. City, 7	Town, or	Location of	of Death	March		unty of Death		Ъ
	Examin		Eastpoint Nursi	-	,		Balt					Ва	ltimor	е	
	Funeral Director		5. Social Security Number 216–24–3568	6. Sex 1 ☐ M 2/C/4F	7. Age (In yrs. 93	last birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Day Sept. 8	y, Year)	9. Birth Cou Mary	place (State o ntry) Land	r Foreign
	land DW		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside Cit	ty Limits
	Mary a-f shu	tor	Maryland Balti	nore	M	iddle 1	River							1 🗆 Yes	30 No
	ith the	Oirec	10e. Street and Number				10f. Zip					10g. Citizer	of What Cou	ntry?	
	s 23a	ral	17 Armor Court	10.111.0			212			-:-0 (0	aif. Vac as No	U.S.	A. Race - Ameri	oan Indian	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 le marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exam har must be natified at ances.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marriad 3 ▼Widowed 4 □ Divorced	Armed For	\$€Zvo		was Deced If Yes, spec	ify Cuba	spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		Black, White		
21215-0036	2 hou	ted	15. Deceden	t's Education		16a. Dece	dent's Usua kind of wor	l Occupa	ation	t of worki	na	16b. Kind	of Business/In	ndustry	
215	ithin 7 9e. han "r	Completed	Elementary/Secondary (0-12)	college (1	-4or 5+)	life.	DO NOT us	e retired)	t or works	''g	Choo	Manuf	acture	r
	filed with Hygiene other tha	Co	7 17. Father's Name (First, Middle,	l ast)		Asse	mbler		18. Mothe	er's Name	(First, Middle,			acture	L
anc	Mental H arked ot atic ever	Be c	James Chamberla								carbouc		,,,,,,		
Maryland	2 should and Men le marke aumatic	To	19a. Informant's Name/Relations				-		and Numbe	er or Rura	Il Route Numbe	er, City or To			
	Health a Health a tem 27 le		Gary Lee Lancas	ter (Son)	look 5						ore, Ma				
ore	iges 1 it of H if Ite		20a. Method of Disposition 1			Place of Disponentery, cre xlar C			e) IN		5, 200		ion - City or T lings -		and
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		' 4 □Donation _ 5 □Other (S	N. Marting Community of Contract of Contra	yva.						Funera				
Ba	Departing Department of the popular in popul		(/se				1407 (old :	uzazı Easte	inski ern A	venue,	Essex	e, P.A , Mary	iand 2	1221
	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	complications that conly one cause on e	aused the deat ach line.	Pa A A								Approximate Interval Bett Onset and I	ween
	/Medical Examiner		Immediate Carse (Final disease or condition resulting in death) a. Acule Respiration Failure Due to (or as a consequence of): Chronic Obstructive Pulmonary I									1 10 01			
	Exammer	J.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	uence of):	melle	4	rus	mon	ary U	wess			
	uted 3 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	\											
oʻ	te be executed ysician and ie burial-transit	Еха	resulting in death) Last	Due to (or as a consec	quence of):									
8760,	ate be	dlcal		d											
O. Box 6	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		inth 2 ☐ Feta ant at time of c	al death 3[⊒Ectopic pro □ Other (sp					23d	Date of delive		Year
ds, P.O.	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditi	ons contributing to de	eath but not res	sulting in the i	underlying ca	ause give	en in Part I			obacco use		the cause of d	leath? Jnknown
Vital Records,	e la has ye 2	Completed									24a. Was autor perfo	osy ormed?	prior to co death?	opsy findings ompletion of c	available ause of
tal		e Co	25. Was case referred to medical	ı T					26 Place	of Deat	1 ☐ Yes	2 No	1 🗆 Yes	2 No	
Ē		O B	examiner? 1 ☐ Yes 2 No	Hospital:	npatient 2] ER/Outpatie	nt 3 DO	A Oth	200	ursing Ho			Other (Spec	ify)	
n of	ding Phye I. After this funeral di	on: T	27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		8c. Injun Worl			28d. Describe	how injury o	ccurred		
Division	Attending ir death. ector: After by the fune	cati	2 Accident invest	gation not be	of Injury - At h	nome farm st	M factory		Yes 2 🗆		28f. Location (Street and N	umber or Rui	al Route Num	ber.
<u>></u>	al or Attendate after death	Certification:	4 ☐ Homicide determ	buildi	ng, etc. (Speci	ify)	root, raotory	, 011100			City or To				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		ng Physician: To the Examiner: On the b and man		ation and/or in	nvestigation,	, in my o	pinion, dea	ath occurr	ed at the time,	date and pla	ice, and due	to the cause(s	
	To the Comp	Ň	29b. Signature and title of control	ith -	512	20	290	. Licens	number	7)		29d. Date s	igned (Month	Day, Year)	
			7	who gameleted	on of don't liv	m 22a) (T	Drine)	~~				210	5/20	105	
	1		30. Name and address of person	M. To	RRES	MO	441	5.1	= Chi	ood	AUG [BALTO	MO	2128	24
	Sta Registi		31. Date filed (Month, Day, Year	AR 03 200	agistrar's a go	ature	I. A	DA.			AUE, (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SSITER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Ye MARCH 2 Birthplace (State or Foreign Country) 7. Age (In y 6. Sex **Funeral** Days Hours 1**X** M 2□ F -34-216 6301 Director TAT Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or Itams 23s or 28a-f show other traumatic evant, the Modical Examiner must be notified at 1 XYes 2 ☐ No Director MARULAND 10g. Citizen of What Country? 10e. Street and Number MARK LAKE DR. RUID Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 NO 1 Never Married 2 Married 1 Yes 2 No Specify: Specify Maryland 21215-003 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) REPAIRMAN 2+HGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be find Mental H WALTER ASSITER 2 LILLIAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or other tra-FRANCES MOORE 512 ROBINWOODAVE. OUSIN BALTO, MD. 21201 more. 20a. Method of Disposition
1 △Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date CEME 03-04-05 * 4 ☐ Donation 5 ☐ Other (Specify) LAUREL 22. Name and Address of Facility, 21. Signature of Funeral Service Licensee BROWN JR. FUNERAL BALTO, MD. 212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or, as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Examiner burial-transit Due to (or as a consequence of) attending physician 68760 pe the Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has 1 Yes 2 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: Inpatient 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) His 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After t Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 | Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Name and

Date filed (Month, Day, Year)

MAR 03

2005

DHMH 17 Rev 1/2001

4

39. Registrar's Signature

address of person, who completed cause of death (Item 23a) (Type, Print)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Year Berthe Lawrence 11:45an 2005 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Bultimore NA Homewood Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 280F 9 Months Days 2 18 4909 Yrs Director No Carolina 1911 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Md. NA 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21213 1645 Cliftview Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Detes: Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: δ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Other People Home Domestic 8th grade 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be Matilda Lawrence Fred ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy N. Lawrence 20a. Method of Disposition 1645 Cliftview Ave., Baltimore, Md. Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State King Mem. Pk. 3-7-05 Randallstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. 1101 E. North Ave. Bla March F.H. East wa عمد 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Muti- Inferct Untraum Examiner Due to (or as a consequence of) Physician/Medical Examiner resnoverenter Accident i or Attending Physician: The law requires that the death certificate be exected after death.

Director: After this certificate has been signed by the attending physician and in by the funcated infector, page 2 should be datached for use as the burnar-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Box 68760 Hypertensies

Due to (or as a consequence of): Unknown Division of Vital Records, P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HEART þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 1 XNatural 2 ☐ Accident 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Atte within 24 hours after de:
To the Funeral Director completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/1/05 D0059056 MD 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)

Lawrence

Socha

1600

MO 32 Registrer's Signature west MT Royal Are

Balt MD 21217

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 10f per fh 8841 3-3-05 vt.
State of Maryland / Bepartment of Health and Mental Hygiene 0 0

		•	For Stete Registrar	State of Marylan		artment of H tificate of			giene Reg. No.	07107	
	Physicia		Decedent's Name (First, Middle, Last) JULIUS			LEVY		2. Date of Dea	ath RY ^{Da} Ž7, 2ÖÜ	3. Time of Death 7:00 AM	
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	Location of Death	n	4c. County of Dea	ith	
			2117 CHARLES HEI	NRY LANE			BALTIM			.TIMORE	
	Funeral Director		5. Social Security Number 6. Sex 219–22–4879	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Day	, 1928 9. Bit	thplace (State or Foreign ountry)	
	w	1	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ecation				10d. Inside City Limits	
	Maryl f sho	for	MD BAL	TIMORE	RAI T	IMORE				1 ☐ Yes 2 ☐ No	
	r 28a	Director	10e. Street and Number	TITIONE	DI LE I	10f. Zip Code			10g. Citizen of What C	ountry?	
	23a c	ai D	2117 CHARLES HEN	RY LANE			21208 -	21209		USA	
36	d within 72 hours after death with the Maryland Jiene. r than "neturel", or Hems 23e or 28e-f show the Medical Extrement and ke ricillis of all	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🂢 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)	- 14. Race - Am Black, Whi		
9	2 hou		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	dvia	16b. Kind of Business		
Maryland 21215-0036	within ene. then	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired SMAN	auring most or woi ii)	rking	JEWELRY		
פַ	ent,	BeC	17. Father's Name (First, Middle, Last)		,		18. Mother's Nar	ne (First, Middle,	Middle, Maiden Surname)		
ylaı		5 F	SOLOMON		LEVY		CCA	GOLDBERG			
Mar	C1 42 00 00		19a. Informant's Name/Relationship (Ty STUART LEVY / SO				er, City or Town, State, SBURG,MD(2				
	Health tem 27 other tr		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other place	20c. Location - City o				
ē	Paga: ento nt: If ry or		1 X Burial 2 ☐ Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)			IUNO ARLII		01/2005	BALTIMORE	, MD	
Baltimore,	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service License		NSON & BROS	., INC. , MD 21208					
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	sha	ter the mode of dyin			rrest,	Approximate Interval Between Onset and Death M. WLLC	
	LXammer	74	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					Years	
	uted d ansil	Examiner	Cause (Disease or injury that initiated events	ASC	UB					Yeur	
68760,	icate be executed physician and s the burial-transil		resulting in death) Last	Due to (or as a consec	quence of):						
	icat phy ths	ledical									
.O. Box	The law requires that the death certificate to the law been signed by the attending physicage 2 should be detached for use as the topical to the law that the law	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	,		23d. Date of de Month	Day Year	
Vital Records, P.	uires that signed by	þ	Part II. Other significant conditions con Aortic Valor			inderlying cause giv	ren in Part I.	23e. Did t	obacco use contribute Yes 2 No 3 7	to the cause of death? Probably 4 Unknown	
CO	aw requir ts been si 2 should	Completed	Chrone Afri	el f. Grillet	n			24a. Was	an 24b. Were a	utopsy findings available	
Re	n: Tha la icate has r, page 2	mo	Ceremouse	Was Deserge					ormed2 death?	completion of cause of s 2 No	
ital	certifica rector, p	BeC	25. Was case referred to medical					ath (Check only o	one)		
of V	Physicien: this certificand director,	ည	1 ☐ Yes 2 ☐ Ño	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	nt 3 DOA			dence 6 Other (Sp	ecify)	
on	ding h. After fune	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No	200. 2000.100	now injury coodined		
Division	of or Attending after death. Director: After din by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office		28f. Location (. City or Tox	Street and Number or F wn, State)	Rural Route Number,	
_	Hospite 4 hours Funerel	edical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my kniner: On the basis of examinating and manner stated.	owledge, deal ation and/or in	th occurred at the to	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	as stated. se to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0	Α.	29c. Licens			29d. Date signed (Mor		
)			SIM	dum my)	VO	004701		2/25/0	5	
	8		30. Name and address of person who c		т 23а) (Туре	, Print)					
	Str	ate	S; H MACINOS 31. Date filed (Month, Day, Year)	3635 32. Polistrar's Sign) \2					
	-		MAD 113 7	HILLS I INCO.	L	- All :					

			For State Registrar	State o	f Marylan		artment of H	Health and M <i>Death</i>		giene Reg. No.	005	07108
			1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		Mary L. Leemore						MARCH	2	2005	11:52 AM
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		1 1 1 1	or Location of Death		4c. C	ounty of Death	
			St. HGNES HE	ALTHCARE			BALTIM				N/A	
	Funeral			6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Birti (Month, Day	h /, Year)	9. Birthp Coun	lace (State or Foreign
	Director		242-32-6686	ILIM ZLAF	85	Yrs.			01-03-19	20	South	Carolina
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				1	Od. Inside City Limits
-	ith the Marylan or 28a-f show e rictified at	5					altimore					1 Yes 2 □ No
3	the N	ect	MD N/	1		Dx	10f. Zip Code			10a. Citize	en of What Coun	ntry?
	with	ā	3813 Rokeby Road				21229	1		US		,
1	iffer death with the Maryla or Items 23a or 28a-f show it at trust be rediffed at	era	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.		Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No-		I. Race - Americ	
(0	after dea or Items	Ξ	1 ☐ Never Married 2 ☐ Marrie	Armed Fo	edent Ever in U orces? 2 X No				Rican, etc.)		Black, White,	etc.
03(al', o	by	3 ☐ Widowed 4 Ž Divorced	If Yes, Gr Year or D	ve lates:		1□Yes 2XNo	Specify:		S	Specify: Black	
21215-0036	filed within 72 hours after death with the Maryland Hygiene Hydiene Hydiene 13a or 28a-f show shit, the Medical Exarch artifical Enditod at	Completed by Funeral Director	15. Decedent' (Specify only highest			(Give	dent's Usual Occup	during most of work	ina	16b. Kind	d of Business/Inc	dustry
21	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	*				
21	e filed within al Hygiene. other than vent, the Me	Co		4			Beautio		- (First Middle		osmetolog	У
pu	be fil Ital H Id oth	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Nam	•		umame)	
7 5	2 should be to and Mental I is marked or raumatic eve	2	Daniel Alford	in (Time Deint)		10h Maili	na Address /Ctmot	t and Number or Run	uise Alfo		Tour State Zin	(Cado)
Maryland	s 1 and 2 should be filed withing Health and Mental Hygiene- item 27 is marked other than other traumatic event, the Man		19a. Informant's Name/Relationsh Shelia D. Titus/					d Baltimore,		-	rown, State, Esp	Code)
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		Shelia D. Titus/	Jaugnter	20b. I		osition (Name of matory or other pla		Date		ation - City or To	own, State
יסר	Pages nent of It int: If ite iry or of		1 Burial 2 ☐ Cremation		State			1	05		-	
	it. Partme		' 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		WOOD	llawn Ce	DECETY 2. Name and Addre	03-09-	US _	Baltı	more, MD	
Ва	permit. Departr Importa any inj		1. mela)	anne				L Home 638 N	Cilmon	C+ Da	74:	MD 01017
	नापुडाटांबा। /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of the disease or condition resulting in death)	complications that only one cause on a	caused the dear							Approximate Interval Between Onset and Death
/	be executed mician and purial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irijury that initiated events resulting in death) Last	c	(or as a consector as a consector as a consector)	quence of):						
687	ficate physis the	edic		0								
EEMORE P.O. BOX	that the death certifica ed by the attending phy detached for use as th	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 [No 9 □ Unknown	1 Live	itcome of pregn birth 2 Feta nant at time of d	al death 3	⊒Ectopic pregnanc □ Other (specify)	гу		23	d. Date of delive Month	ory Day Year
U CE	The law requires that the tee has been signed by thoage 2 should be detached.	by	Part II. Other significant conditio	ns contributing to c	leath but not res	sulting in the u	underlying cause gr	ven in Part I.	23e. Did to	~		ne cause of death?
NAR	aw rei	Completed		Colon	Tu	new			24a. Was	an	24b. Were auto	psy findings available
≥ and	The la ate ha page á	mo mo							autop perfor	media 2 No	death?	mpletion of cause of
		O.	25. Was case referred to medical					26. Place of Deat		/ `		
> :	yalcian: is certific director,	To B	examiner? 1 ☐ Yes 2 ☐No	Hospital: 1	npatient 2	ER/Outpatie	nt 3 DOA	her: 4 🗆 Nursing Ho	ome 5 Resid	lence 6	☐Other (Specify	y)
0	ding Ph h. After th funeral		27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o			28d. Describe h			
io i	Ntendin death. ctor: Af y the fur	atlo	Natural 5 Pending	ation]Yes 2□No				
Division of Vital	To the Hospital or Attending Phyalcian: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	nod 208. Flac	e of Injury - At h ling, etc. (Speci	iome, farm, st	reet, factory, office		28f. Location (S City or Ton	Street and m, State)	Number or Rura	ll Route Number,
-	he Hospl in 24 hou he Funer pletely fill	edical	29a. Certifier Check only one) Check only	xaminer: On the b	e best of my kn pasis of examina nner stated.	owledge, deal ation and/or in	nvestigation, in my	ime, date and place, opinion, death occur	red at the time,	date and p	elace, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		ha in			se number	_	29d. Date	signed (Month,	Day, Year)
	,		Cher				Do	006136	20	MA	ret 2	5002
	4		30. Name and address of person	PUMINO	72 0	ACNE		-CH CANE	= BA	CTIN	ront 1	nus 21225
	Sta		31. Date filed (Month, Day, Year)		Registrar's Sign	ature	and !					

		•	For 1 = State Registrar	State of	Maryland		artment of				giene 0	05	07109
	Physici	an	1. Decedent's Name (First, Middle,	Meyersbur	ro					Date of Dea Month	Day	Year 1005	3. Time of Death 5:30 PM
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town,	or Location		bruary	4c. County		J:30 -
			Mariner Health At Ci					ingto				ntgome	
	Funeral Director		5. Social Security Number 085-05-9970	6. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs. la 92		If Under 1 Year Months Days		Min. SI	Date of Birth (Month, Day EP 16,	1912	9. Birthp Cour New	lace (State or Foreign stry) York
	end w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
	Maryl e-f sho	tor	Maryland Mont	gomery		I	Kensingt	on					1 Yes 2 No
	or 286	Direc	10e. Street and Number				10f. Zip Code	0895		1	10g. Citizen of		ntry?
	leath v	eral	9910 Summit Ave	12. Was Dece	dent Ever in U.	5. 13.	Was Decedent of If Yes, specify Cul		igin? (Specify	Yes or No-		JSA ce - Americ	an Indian,
036	ours after or rai', or iten	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For	ces? 2. ZWo e		If Yes, specify Cul			an, etc.)	Specif	ck, White, y: Wi	etc. nite
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23a or 28e-f show any fujury or other traumatic event, the Medical Examinar must be natilised at Ance.	Completed by Funeral Director	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	College (1-		(Give life.	dent's Usual Occu kind of work done DO NOT use retin	during mos ed)	at of working		16b. Kind of B		,
q 5	filed v Hygie other t	CO	17. Father's Name (First, Middle, L	ast)		Antic	que Deal		er's Name (F	irst, Middle, i	Self F Maiden Sumar		<u>red</u>
Maryland	Mental Mental arked c	To Be	Joseph S. Ros	enberg		,			Helen H	_			
Mar	d 2 sho th and 7 is mu traum		19a. Informant's Name/Relationsh Richard Meyersb				ng Address (Street Devere				r, City or Town, ing,M		
re,	item 2 other		20a. Method of Disposition		20b. P!		sition (Name of matory or other pl		Date		20c. Location		
Baltimore,	Page Iment tent: if lury or		1 ☐ Burial 2 MCremation `4 ☐ Donation 5 ☐ Other (Sp		Met	ro Cre	ematory,	Inc.	3/1/0	5		imore	e, MD
Bal	permit Deper Impor any in		21. Signature of Funeral Service L	regor		29	remation 99 Frede	<u>rick R</u>	Road I	Baltim	ore, M	nc. 2122	
			23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on ea	ach line.	. Do not ent	er the mode of dy	ing, such as	cardiac or re	spiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Pneum Due to (ON1a or as a consequ	ience of):						-	
	Examiner		Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequ	ience of):						_	
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	G.								10	
60,	te be executed ysicien and te burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequ	ience of):							
68760,	g phys as the			d									
.O. Box	es that the death certificate be executed igned by the attending physicien and be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 KNo 9 □ Unknown		inth 2 ☐ Fetal ant at time of de	death 3[□Ectopic pregnan □ Other (specify)	су				ate of delive onth	ery Day Year
S, D	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant conditio	ns contributing to de	eath but not resu	ulting in the u	nderlying cause g	iven in Part I	l		bacco use con		ne cause of death?
Vital Record	The law resete has bee page 2 sho	Completed								24a. Was a autops perform	sy med?	prior to condeath?	psy findings available mpletion of cause of 2 No
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				her	e of Death (C				,
of	ding Physician: The I h. After this certificate ha funeral director, page	n; To	1 ☐ Yes 252 No 27. Manner of Death	28a. Date o	npatient 2 of Injury h, Day Year)	ER/Outpatier 28b. Time o Injury					ence 6 Doth ow injury occur		Y)
Division	Attending ir death. ector: After by the fune	catlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation			M 1[∃Yes 2□	-	Lanctine /C	troot and Alumi	has as Russ	l Route Number,
Divi	D it to	Certification:	4 Homicide determi	and 289 Place	ng, etc. (Specify	/)	reet, factory, office	,	201.	City or Town		Der OF FIDIA	a noute wanted,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director:	edical (29a. Certifier 1 Certifyin (Check only one) 1 Medical I	g Physician: To the Examiner: On the ba and mann	asis of examinat	wledge, deat tion and/or in	h occurred at the vestigation, in my	time, date ar opinion, dea	nd place, and ath occurred	due to the cat the time, d	ause(s) and m late and place,	anner as s and due to	tated. the cause(s)
)	vithin To th	Ä	29b. Signature and title of certifier	mon	Ba,	MO		ose number	7/2	1	29d. Date signe		
	18		30. Name and address of person of Troum Bao	13.2	19 2	xecul	Print)				antewn		4580E C
	Sta Registi		31. Date filed (Month, Day, Year)	2005 32. R	egistrar's Signa	ture # A	onle						

			State of Maryland	•				al Hygie	ያግ በ 5	07110
			1 - State Registrar	Cer	tificate o	of Deat		Reg	No.	
	Physici	an	Decedent's Name (First, Middle, Last)				M	ate of Death Ionth	Day Year	3. Time of Death
	/Medic	al -	Grace M. Melrose		4b Ciby Tou	vn, or Locatio		arch	4c. County of Dear	
4	Examin	er	4a. Facility Name (If not institution, give street and number)	1-	•	erna			Anne A	
	Eupoval		Heartlands at Severna Parl 5. Social Security Number 6. Sex 7. Age (In yrs. le	K ast birthday)	If Under 1 Y	ear If Und		ate of Birth Month, Day, Ye		thplace (State or Foreign ountry)
	Funeral Director		051-16-7318 1 1 M 2 F 8	3 Yrs.	Months Da	ays Hours		R 1, 1		w York
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	antion					10d. Inside City Limits
	shov	2		, TOWIT OF LO		everna	Dorde			1 ☐ Yes 2 ☐ No
	the M	Funeral Director	Maryland Anne Arundel		10f, Zip Co		Palk	10a.	. Citizen of What Co	ountry?
	with Ba or					.146			USA	
	death ms 2;	era	715 Benfield Road 11. Marital Status 12. Was Decedent Ever in U.S.	5. 13.			Origin? (Specify)	res or No-	14. Race - Ame	
9	or the	Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give		rres, specily 1 □ Yes 2X0			i, etc.)	Black, White	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or tlems 23a or 28a-f show the Macked Examinet must be maillied at	Completed by	3 XWidowed 4 ☐ Divorced Year or Dates:							White
15-(netu	iete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Q kind of work d DO NOT use r	lccupation lone during m letired)	ost of working	161	b. Kind of Business	rindustry
12	withly ene. than	duc	Elementary/Secondary (0-12) College (1-4or 5+)				stration		State Go	vernment
d 2	filled Hygi other ent, L		12 17. Father's Name (First, Middle, Last)				ther's Name (Firs			
lan	lid be fental rked tic ev	To Be	William Charles Milliken				Olive N	May Bar	ker	
Maryland	s ma		19a. Informant's Name/Relationship (Type, Print)						ity or Town, State,	
Σ.	and 2 ealth n 27 I		J. Peter Melrose/Son	-					n Park, I	
altimore,	ges 1 t of H if iter or oth		1 Burial 2 M Cremation 3 Hemoval from State		sition (Name of matory or other		Date		c. Location - City or	
Ë	tmen tent:			ro Cr	ematory	y, Inc	3/3/05	5 <u>F</u>	Baltimore	, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or items 23a or 28a-f show any injury or other treumatic event, the Markical Examinating the nutilised at once.		21. Signature of Funeral Servi Vicensee	Č	rematio	on Soc	iety of	MD, In	c. re, MD 21	220
	_		Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	1. Do not ent	er the mode of	f dying, such	as cardiac or res	piratory arrest	re, MD ZI	Approximate Interval Between
	Pnysician									Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. CHRONIC Due to (or as a consequence)	uence of):	RULL III	UL I	CC CO CC SUP	77-7	145730	
	Examiner		Sequentially list conditions b.							
	D H	iner	Supentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	zence of).						
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C	uence of):						
760,	be executed sician and burial-transit	cai E								
687	w ~ 0	edi	d.							
Вох	n certificat anding phy use as th	N/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal		⊒Ectopic pregr	nancy			23d. Date of de	•
	0 0	Physician/M	in the past 12 mooths? 1 Yes 2 No 4 Pregnant at time of de		Other (speci				Month	Day Year
P.0	by tac	Phys	9 Unknown	. Mai		an and in Do		23a Did tahar	noo usa contributa t	o the cause of death?
	Se us	by	Part II. Other significant conditions contributing to death but not resu	uting in the u	nderlying caus	se given in Pa	irt i.			robably 4 Unknown
orc.	requ	Completed						24a. Was an		utopsy findings available
3ec	e la has	mpi						autopsy performe	d? prior to death?	completion of cause of
Vital Records,	icien: The l certificate ha rector, page	e Co	25. Was case referred to medical			26 PI	ace of Death (Ch		No 1 □ Yes	2 □ No
	Physicien: this certific ral director,	o B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	Othor			se 6 Dother (Spe	SSISTED
10		n.T	27. Manner of Death 28a. Date of Injury	28b. Time o		Injury at Work?	28d.	Describe how	injury occurred	,
ior	f A P di	atio	2 Accident investigation		М	1 Yes 2				
Division	l or Atten after deat Director: in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide		reet, factory, o	ffice	28f. L	ocation (Stree City or Town, S	et and Number or A State)	ural Route Number,
	pitel o	S	29a. Certifier 1 Certifying Physician: To the best of my kno	uuladaa daal	th conversed at t	the time date	and place, and o	tue to the caus	se(s) and manner a	e stated
	24 ho 24 ho Fund etely f	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno (Check only one) 2 Medical Examiner: On the basis of examinat and manner stated.	tion and/or in	ivestigation, in	my opinion,	death occurred at	the time, date	and place, and du	e to the cause(s)
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Med	29b. Signature and title of certifier			icense numb		29d	. Date signed (Mon	
	2		money ms		J	57	531		March	3, 2005
1	D,		30. Name and address of perso who completed cause of death (Item	n 23a) (Type,					12.00	
_	\ <u>\</u>		mohit Negi 8601 Ve	teria.	as Mu	uy 1	m(less	ville	, NO 21	103
		ate	30. Name and address of person completed cause of death (Item Michael Neg & G C V e e 31. Date filed (Month, Day, Year) MAR 0 3 2005	iture	matte s					
	Regist	rar	MAR 0 3 2005 Plaser 1	15° /5	-					

•1502 • 1	For Unpend Item 23a,pt.II,27,28a-f	partment of Health and Mental H per me G841 3-11-05 tas Prifficate of Death	ygiene 005 07111
1	1. Decedent's Name (First, Middle, Last)	2. Date of D	Death 3. Time of Death
Physician /Medical	Michael Edward Mullin	Febru	ary 27, 2005 10:58 AM
	a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
20	Harford Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Havre de Grace Ji If Under 1 Year If Under 24 Hrs. 8, Date of E	Harford 9. Birthplace (State or Foreign
Funeral	216–56–6901 1XI M 2 F 54 Yrs.	Months Days Hours Min. (Month, I	Day, Year) Country)
	Usual Residence of Decedent		
arylar show	10a. State 10b. County 10c. City, Town or I		10d. Inside City Limits 1 ☐ Yes 21 No
the M	Maryland Harford Havre d	10f. Zip Code	10g. Citizen of What Country?
after death with the Maryland after death with the Maryland or Items 23s or 28s-1 show therefore the mortified at Funeral Director	127 Deaver Street	21078	USA
death death		. Was Decedent of Hispanic Origin? (Specify Yes or North Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
036 urs after al', or lit	1 Never Married 2 Married 1 X Yes 2 No 1909	1 ☐ Yes 2 X No Specify:	Specify: White
5-0036 72 hours aft instural; or	3 ☐ Widowed 4 ☒ Divorced Year or Dates:	edent's Usual Occupation	16b. Kind of Business/Industry
215 nin 72 nin ing	(Specify only highest grade completed) (Giv 	e kind of work done during most of working DO NOT use retired)	
21215-00 ed within 72 hou ygjene. Per than "naturn it, tre Medical it, tre Med	12 Col	ınselor	Drug Rehabilitation
Maryland 2121 d 2 should be illed within th and Mental Hygiene. I? Is marked other than "treumatic event, tre Me. To Be Compli	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd. Emma Rueli	
ryla hould d Men marke matic	Nicholas Mullin Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Route Num	
Manuellith and 2 s 27 Is ir treu		Orbitan Road Parkville,	
other	20a. Method of Disposition 20b. Place of Disp		20c. Location - City or Town, State
altimore, mit. Pages 1 ar mit. Pages 1 ar pariment of Hear portent: if Item; y injury or other ce.		rematory Inc. 3/3/05	Baltimore, Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be ilied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other treumatic event, the Medical Evantuar injurity any once. To Be Completed by Funeral Director	21. Signature of Funeral Sarvice Usersee Thomas Gregor	22. Name and Address of Facility Transtion Society Of Mary 199 Frederick Koad Baltin	land Inc. more, Marvland 21228
HUES	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		arrest, Approximate Interval Between
Physician	Immediate Cause (Final disease or condition resulting in death) Methadone intoxica	tion	Onset and Death
/Medical Examiner	Due to (or as a consequence of):		
<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (cleases or injury		
executed executed in and in-transit Examiner	trial initiation events C.		
9760, ate be executed hysician and the burial-transi	resulting in death) Last Due to (or as a consequence of):		
58760, icate be executed physician and sthe burial-transit edical Examir	d		
Box 6(eath certific	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
P.O. Box 6 thet the death certifit ed by the attending r detached for use as Physician/Me		□Ectopic pregnancy □ Other (specify)	Month Day Year
s thet the ned by a detac	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
cords, w requires been sign should be	Cirrhosis Of The Liver	10	Yes 2 No 3 Probably 4 Maunknown
0 8 8 0		24a. Wa auti per 117 Yes	opsy prior to completion of cause of death?
sion of Vital Retending Physicien: The Beath. tor: After this certificate his the funeral director, page cation: To Be Com	25. Was case referred to medical examiner?	26. Place of Death (Check only	v one)
Of N	12 Yes 2 No Hospital: 1 Inpatient XXEP/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time	The state of the s	sidence 6 Other (Specify) s how injury occurred
ding F After funerr flon:	1 Natural 5 Pending Found th, Day Year) Injury	of unk 28c. Injury at Work? M 1 □ Yes 2 √ No	e how injury occurred unk
S page I	2 Accident 3 Suicide 4 Homicide A Could not be determined 2-2/-05 28e. Place of Injury - At home, farm, s building, etc. (Specify) Scene	treet, factory, office 28f. Location City or To	(Street and Number or Rural Route Number, own, State) 127 Deaver Street
_ er sing	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of my knowledge, deal and manner stated and manner stated.	ith occurred at the time, date and place, and due to th	
Me Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
ill's	Hamete Borethall, MB	OCME	February 28, 2005
21/ April	30. Name and address of person who completed cause of death (Item 23a) (Type Pamell E. Southuil M)	n. Print) 111 Penn Street Balti	more, Maryland 21201
State Registrar	31. Date filed (Month, Day, Year) MAR 0 3 2005 32. Resultrar's Signature	Joseph	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) MARCH **Physician** 8:50 AM MARSHALL wos HORTENSE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Huspita Baltimore Year If Under 24 Northwest 1 Year Birthplace (State or Foreign Country) If Under Date of Birth (Month, Day, Year) 2-28-4 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 212-22-4949 1 ☐ M 2 🗓 F Yrs. **Birector** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location , 1 Yes 2 No Baltimore Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1152 N. 1 12. Was Decedent River in U.S. Armed Forces? 1 ☐ Yes 2 11 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Quban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ntary/Secondary (0-12) College (1-4pr 5+) Humemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Eunice Juna 19a- Informant's Name/Relationship (T 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kedae Catonsville Oliver Arderson 20b. Place of Disposition (Name of country, crematory or other place) 20a. Method of Disposition Date Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State baltimore ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Greene Funeral Shc. MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ (lenal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this Manner of Death 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 24 hours after death. investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29d. Date signed (Month, Day, Year) 29b. Signature and title of q 0 MARCH 1, 2005

Registrar

State

30. Name and address of

31. Date filed (Month, Day, Year,

NWHC

and cause of death (Item 23a) (Type, Print)

IMPERIAL
32. Registrar's Signal

05-1566 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MICHAEL MAULTSBY State of Maryland / Department of Health and Mental Hygiene
For Unpend Item 23a,27,28a-f per me G341,3-11-05, tas
Registrar Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 Year MARCH **Physician** 1631 P M Michaeldinautsb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY SINAI HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 6 - 3 - 6 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2□ F Months 215-60-633 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mantal Hygiene. Important: if Item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be multified at 20.00. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Ves 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Bely enue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nentary/Secondary (0-12) College (1-4pr 5+) Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Moults Lenora c ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore 4102 Belv ltshu(WiFe leu 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Teremation 3 Removal from State Baltimore oreen mount baltimore IIID eens Funeral Service * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility dallstown, IND 21132 23a. Part1. Enter L. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Narcotic intoxication **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit attending physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ed by the a 1 ☐ Yes 2 ☐ No. 9 🗆 Unknown s been signed by till should be detach. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 🗆 No 2 No Yes certificate Yes r: After this certifica e funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Yes 2 🗌 No 28b. Time of **unk** 28c. Injury at Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 2-28-05 the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4102 Bellview Ave. Baltimore, MD

NIA

Year

Attending Physician: within 24 hours after death To the Funeral Director: filled in by ŏ

6 X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Home Baltimore, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of MARCH 2, 2005 OCME

who completed cause of death (Item 23a) (Type, Print) 111 Penn Street 30 Baltimore, Maryland 21201

State Registrar

completely

Medical

32. Registrar's Signature

MAR 03 2005

31. Date filed (Month, Day, Year)

Mattheu, Henrietta Baltimore, Maryland 21215-0036

			Please	State of Ma							-		_	
		-	For State Registrar	State of Mic	zi y lai i				Death	aria ivi		Reg. No.		0/114
			Decedent's Name (First, Middle, Last)						1	2. Date of De			3. Time of Death
	sicia edica		Henrietta		e	Matt				(Februa	My d	18 2005	
Exa	mine	r	4a. Facility Name (If not institution, give	11 .	1.1		4b. City	, Town, or	Location o	of Death		# 4c.	County of Dea	ath
Fune	ral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs.	last birthday)		or 1 Year	If Under 2	24 Hrs.	8. Date of Bir	th V Vear	9. Bi	hthplace (State or Foreign ountry)
Direc				□M 2√F		71 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sept 21	1,19	33 Baľ	to. Maryland
land		-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
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ith the		Olrec	10e. Street and Number				10f. Z	ip Code	0.007	4		10g. Cit	zen of What C	ountry?
72 hours after death with the Maryland natural; or Itams 23a or 28a-1 show		Funeral Director	4918 Marchwood Cou	12. Was Decedent	Ever in II	S 13	Was Dec		8-907		city Yes or No	- I	USA 14. Race - Am	erican Indian.
of the contract of the contrac		Ē	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 If Yes, Give X			If Yes, span			, Puerto F	cify Yes or No Rican, etc.)		Black, Whi	
2-003 72 hours a		ğ	3 XWidowed 4 ☐ Divorced	Year or Dates:					Specify:					
72 h		Completed	15. Decedent's Edi (Specify onfy highest grad	ie completed)		16a. Dece (Give	kind of w	ual Occupi ork done d use retired	during most	t of workir	ng	16b. Ki	nd of Business	s/Industry
Z withi		E O	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Cai	regiv	<i>r</i> er				F	Iome Ho	spice
nd ,		Be C	17. Father's Name (First, Middle, Last)								(First, Middle,			•
yla nould to d Ment narka		2	Charles Nico		lesto	_	na Addros	o (Stroot		Paul			nbs r Town, State,	Zin (nde)
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Page Page ment c			1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Oal	k Lawn								Maryland
Daltimor Department of Mportant: If It	once		21. Signature of Funeral Service Licens		1									Home PA nd 21221
_ 4024		-	23a. Part 1 Inter the disease, or conposhpol, or heart failure. List only of	lications that aused	the deat								магута	Approximate
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/Medic	cal		disease or condition resulting in death)	a. Due to (or as	a conseq	uence of):	10	1101	0	. 1	i			
Examir			Sequentially list conditions,	b. <u>Fach</u> Due to (or as	eal	K50	pha	gea	1	15+L	10			
ted neg		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ESOC.	boo	100	0	anc	PF					
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death cer a attendir		Iclar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at			⊒Ectopic ⊒ Other (s	pregnancy specity)					Month	Day Year
at the by the day the		hys	9 Unknown	9⊡ Unknown		P					02a Did t	obacca i	an anatributa t	e the eques of death?
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v requ		etec									24a. Was	an	24b. Were a	utopsy findings available
VICAL RECORDS, ilcian: The law requires to certificate has been signs eacher page 2 should be	D 20	Completed									autor		prior to death? 1 \(\sum \text{Ye}	completion of cause of
ian: J	5	BeC	25. Was case referred to medical examiner?							of Death	(Check only o	-A-		
OI V Physic	3	0	1 ☐ Yes 2 No	Hospital:		ER/Outpatier			4 □ Nu				5 ☐Other (Spe	ecify)
ding F After		tlon	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	M	28c. Injun Worl			28d. Describe I	now injui	y occurred	
l or Attending after death. Diractor: After the fines	e s	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At he	ome, farm, st	reet, facto	ory, office		2	28f. Location (: City or To			tural Route Number,
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- > - () Thu	1 try		(PV4)		118	871	17		07-	28-0	5
17	,		30. Name and address of person who	completed cause of d	eath (Iten	n 23a) (Type,	Print)	Saut	1.10	0	a hall	L:	A 144	D. 21237
U.	Stat	e	Dr. Stephen Se 31. Date filod (Month, Day, Year)	32. Registr	ar's Signa	ature .		YOU	416	NITU	<u> </u>	uni	116,111	V: 5105/
Por	rietrs	٠. ١	MAD AR C	005	Paris e	16	Coast	1.3						

			For State Registrer	State of Ma	aryland		rtment of F	Health and N Death	Mental Hy	giene	15	07115
	Physici		1. Decedent's Name (First, Middle, Last) Betty Jean Mason	n					2. Date of De Month	Day 16.	2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s Mercy Hosptial	treet and number)			4b. City, Town, o	or Location of Death		c. Coyint	of Death	
	. Funeral Director		210 70 3001	M 2√ F 7. Age	in yrs. lasi 4 (birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Date 2 - 1 - 5	rth ay, Year) 9	9. Birth	place (State or Foreign intry) Caro lina
	laryland ebow	or.	Usual Residence of Decedent 10a. State 10b. County MD		10c. City, T	own or Loc						10d. Inside City Limits 12 Yes 2 No
	death with the Maryland ms 23s or 28e-f ehow L. ust be netting st	Director	2603 E. Preston	Street			10f. Zip Code	1213		U.S.A	What Cou	intry?
38	n 72 hours after death with the Maryla "neturel", or Items 23a or 28e-f ehov valical Examiliarinasi barnutlitad at	by Funerai	11. Marital Status 1 Nover Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 27 N If Yes, Give Year or Dates:			as Decedent of a Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	Decity Yes or No Dican, etc.)	o- 14. Ra Bla Specii	ck, White	ican Indian, , etc. lack
215-0	within 72 hou ene. then "neture	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		4)	(Give k life. D		pation during most of work ed)	king	16b. Kind of B		
5 E	be filed wintal Hygien od other the	Be	12th 17. Father's Name (First, Middle, Last) Albert Mason		1	Nursi		18. Mother's Nam				ucy
O N Maryld	d 2 should h and Mer 7 is marke freumatic	으	19a. Informant's Name/Relationship (Ty Mary Burton (Si:				Address (Street	t and Number or Ru	ral Route Numb	per, City or Town		ip Code) MD 2121 2
$\mathcal{M}_{\mathcal{AS}}$	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importents: if item 27 is marked other then any injury or other treumatic event, ITEM, and once.		20a. Method of Disposition To Burial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify)		20b. Plac	e of Dispos	ition (Name of atory or other pla	1	Date	20c. Location	- City or T	own, State
Baltin	permit. P Departme Importen any injur,		21. Signature of Funeral Service License	of some	h			ess of FacilityWes tern Ave	_			
	Pnysician		23a. Part1. Enter the disease of complishock, or heart failure. List only or Immediate Cause (Final	cations that caused ne cause on each lin	Δ	Do not ente	r the mode of dyi		or respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequer			of the s	>>>c	~~		
8760,	rate be executed hysician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as								
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ds, P.	uires that t signed by d be detac	by	Part II. Other significant conditions con	tributing to death bu	ut not resultin	ng in the un	derlying cause gr	ven in Part I.		tobacco use con	tribute to	the cause of death?
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ision (To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day 28e. Place of Inju		Bb. Time of Injury]Yes 2□No	28f. Location (Street and Num		ral Route Number,
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	/Medic		4a. Facility Name (If not institutio	n, give street and numb		yers	4b. City, T	own, or	Location of		epr ua		ty of Death	J 1.33P.
	Examin	er	Ruxton Nursi			enter	Pike	svi	lle			Bal	timo	re
	Funeral		5. Social Security Number		. Age (In yrs. I		If Under 1 Months	Year Days	If Under Hours	Min.	. Date of Birth (Month, Day,		Cour	
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	yland now		10a. State 10b. County	1	10c. City	, Town or Lo	cation						1	0d. Inside City Limits
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	ns 234	Funeral Director	4 Quimper Ct	12. Was Deced		S. 13.1	Was Decede		208 spanic Ori	gin? (Speci	fy Yes or No- can, etc.)	14. Ra	ce - Americ	can Indian,
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yla	hould be id Menta marked matic ev	은	Daniel Lofte 19a. Informant's Name/Relation			10h Mailie	na Address	(Street a			aylor Route Number	City or Town	n. State. Zic	Code)
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imo	nit. Pages partment of l ortant: If its injury or o		Murial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify)	Ga	rriso	n For	cest	. Ve	t. 3/	/3/05	Owing	s Mi	lls, Md
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funday Service	Licensee	har) M	arch	Addres F/F	S of Facility Wes	št	Balti	more.	БМ	21215
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	or complications that ca	used the deat								na	Approximate Interval Between
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89 X	leath certific attending pi	Physician/Med	IF FEMALE:	23c. If yes, outo								23d. D	ate of deliv	ery
Box	death e atter d for u	Iclar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4☐ Pregna	rth 2 ☐ Feta ant at time of d		□Ectopic pro □ Other (spo					N	Month	Day Year
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Division	or Attence after death Director: in by the	Certification:	3 Suicide 6 Coul	d not be 28e. Place	of Injury - At h	ome, farm, st	reet, factory	, office		28	8f. Location (S City or Tow		nber or Rur	al Route Number,
	ital or irs afte ral Dir led in									- 1				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	edical	29a. Certifier 1 TCertify (Check only 2 Medical	ring Physicien: To the al Examiner: On the ba and mann	sis of examina	owiedge, dea ation and/or in	th occurred nvestigation	at the tin , in my o	ne, date a pinion, de	nd place, ar ath occurre	nd due to the o d at the time, o	ause(s) and rate and place	manner as : e, and due t	stated. to the cause(s)
	To the within ?	Mec	29b. Signature and title of certif				290		e number		- 4	29d. Date sign		
	, , ,		•	7	-	\supset			037	573		Februa	my 2	5,2005
	h		30. Name and address of person	on who completed cause	e of death (Iter	m 23a) (Type	Print)	-\	h	^	VA SI	136		
	St	ate	31. Date filed (Month, Day, Yea	ar) 32. Ry	5 Maw	ature	6	2/60	Vern		1- 01	100	-	
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Registrar

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crn	-	For State Registrar	of Maryland	/ Depa	irtment of <i>tificate o</i>	Health and M	ental Hy	giene Rag. No.	2005	07118
O		Hegistrar Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death
Physicia /Medica	al .		rkwood, Sr	•			Februai	ry 2i	7, 2005 County of Death	2:10 P M
Examine	er	4a. Facility Name (If not institution, give street and 998 W. Patrick Street		5	•	n, or Location of Death ederick		46.	Frederic	ck
Funeral Director		5. Social Security Number 6. Sex 1 1 1 M 2	7. Age (In yrs. las		If Under 1 Ye Months Da		8. Date of Bir March	*30°,1	057 Cou	olace (State or Foreign ntry) ngton DC
ath with the Maryland 23e or 28e-1 show ust be neitlied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick		Frede					1	0d. Inside City Limits 1 ☐ X es 2 ☐ No
ith the	Director	10e. Street and Number	- 00		10f. Zip Cod			-	izen of What Cou	
ter death w	erai	120 Alessandra Court #	Decedent Ever in U.S.	13. V	21702 Was Decedent	of Hispanic Origin? (Specuban, Mexican, Puerto	ecify Yes or No		ed State	can Indian,
036 ours after de- ral', or items	Completed by Funeral	Arme	d Forces? les $2 \square No$, Give $1976 - 1$ or Dates:	i i	fYes, specify C		Hican, etc.)			ite
15-00% n 72 hours "netural;	letec	15. Decedent's Education (Specify only highest grade comple		(Give	dent's Usual Oc kind of work do DO NOT use re	ne during most of work	ing	16b. Ki	ind of Business/In	dustry
21215-0 3 within 72 ho jiene. r then "netu	ошо	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)		k Drive	*		Tr	ansporta	ation
tnd be fill htal H od oth	To Be C	17. Father's Name (First, Middle, Last) Scott Markwood				18. Mother's Name	e Sair	ie .		
re, Maryls s 1 and 2 should t Health and Mer item 27 is marke		19a. Informant's Name/Relationship (Type, Print Sherri Markwood, Wife				eet and Number or Run lra Court,				
		20a. Method of Disposition	20b. Plac	ce of Dispo	sition (Name o	f 1	Date		ocation - City or T	
		1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal (4 ☐ Donation 5 ☐ Other (Specify)	rom State	dale F	ark Crem	atory 03/01			erdale, Mar	yland
Baltimore, permit Pages 1 at Department of Hea Important: If item any injury or othe		21. Signature of F	M01113	7	'221 Gra	ayburn Driv		Bur		21061
Physician /Medical Examiner pue	xaminer	Sequentially list conditions, if any, leading to immediate cause. Entire underlying Cause (Disease or injury that initiated events	on each line.	ia dre ince of):		rdial Infarct			ial Film	Approximate Interval Between Onset and Death
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ne Hospitu n 24 hours ne Funere	edical C	29a. Certifier 1 Certifying Physician: (Check only one) 2 X Medical Examinar: On and	o the best of my know the basis of examination	rledge, deat on and/or in	th occurred at the occurred at	ne time, date and place, my opinion, death occur	and due to the red at the time	, date an	d place, and due	to the cause(s)
To the within To the comp	Me	29b Signature and title of certifier Hanshe Tyuthall, I	MD			cense number ME			ate signed (Month ruary 28	
•		30. Name and address of person who completed	Ul, mi)		Print)	Penn Street	t Balti	more	, Maryla	nd 21201
Sta Registr		31. Date filed (Month, Day, Year) MAR 0 3 2005	32. Degistrar's Signatu	TLO	inste					

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Mace Tokumi Miyasaki ECRUARY 24, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOOD SAMARITAN HOSFITAL MORE X7/ Year 7. Age (In yrs. last birthday) Under 1 If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min MM 2 F 217-38-0098 65 Feb. Director 9, 1940 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show or other traumatic event, the Medical Exercises must be notified at XXYes 2 ☐ No Maryland N/ABaltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6203 Blackburn Lane 21212 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ② ANO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status within 72 hours after 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Asian 1 ☐ Yes XIX No Specify: Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Commercial & Industrial Development Group 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) 12 College (1-4or 5+) Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Miyasaki Masao Itono Jesse Omoto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other tra Wife 6203 Blackburn Lane Barbara Miyasaki Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State Baltimore-Washington 3/3/2005 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland Cremator nd Address of Facility 21. Signature of Funeral Service Licensee Burree-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211 First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in re. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ROBABLE MYOCARDIAL INFARCTION Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed for use as the burial-transit THERO SLEROTIC and Due to (or as a consequence of) physician Box 68760 Physician/Medicai the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy performed? certificate 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Medical Certification; To 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending Injury 1 Yes 2 No death. 2 Accident investigation within 24 hours after death To the Funerel Diractor: completely filled in by the Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide ŏ To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) 3(60) LOCH AVEN BOULEVAS HOLTZCLAW, MD JAKTIMORE. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 0 3 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		tment of h		ınd Men		4000	07120
			Registrar 1. Decedent's Name (First, Middle, Last)			modio or	Douin		Date of Death		3. Time of Death
П	Physici		FAUST ANGELO 1	1EVALDE				F	Month Cb o	200 Pay Yeer	
	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, o		f Death		4c. County of De	ath
			****	nd Medical C	nter	If Under 1 Year	10 VC	CA HIS PA	Date of Birth	0.8	inthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. las	Yrs.	Months Days	Hours	Min.	Month, Day,	Year) (Country)
			Usual Residence of Decedent						1		
	arylan ehow	-	10a. State 10b. County	10c. City,	Town or Loca	1					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	10e. Street and Number	IGES HYA	IT'TSVI	10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10	g, Citizen of What C	Country?
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	death	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H Yes, specify Cub	lispanic Orig	in? (Specify Puerto Rica	Yes or No-	14. Race - Am Black, Wh	
36	hours after death with the Maryland tural', or Items 23e or 28e-f ehow al Exertinet must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		□Yes 2 No	Specify:			Specify:	WITE
21215-0036	72 hours after dea "natural", or Items alcal Examinar m	ed b	15. Decedent's Educat		16a. Decede	nt's Usual Occup	ation		1	6b. Kind of Busines	s/industry
215	C _ 9	Completed	(Specify only highest grade c	completed) College (1-4or 5+)	(Give ki	ind of work done O NOT use retire	during most d)	of working		·	
21	fited with! Hygiene, ther ther	Соп		2	MYSK	25 A5	SOCI	ATE	a Middle A	STATEGO	VERNMENT
and	b d la b	Be	17. Father's Name (First, Middle, Last) ANGELO MER	AIDI			D C	rs Name (Fi.	AT	faiden Sumame)	
Maryland	É B E E	မ	19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Street	and Numbe	or or Rural Ro	oute Number,	City or Town, State,	Zip Code)
	1 and 2 s Health ar tem 27 le		PASCALE MERALDI D	AUGHTER "	1941 NE	PASANTE	NOVE	RDRE	STERST	EUN MD.	21136
Baltimore,	ges 1 and t of Healt if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Ren	con	ce of Disposi netery, crema	tion (Name of atory or other pla	сө)	Date	2	20c. Location - City o	
ij	nit. Pages aartment of ortant: If it injury or o		* 4 □ Donation 5 □ Other (Specify)	BAY	VIEW	CREMA	TORYZ	-26-	5 B	ALTIMORE	E, MD.
Ball	permit. Pag Department Important: any injury conce.		21. Signatur of Europa Service License		22.		Family Fun	eral Home		tion Center, P.A.	
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ж 68	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE:	. If yes, outcome of pregnance	**		-			201 5-111	
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J of	ding Phy h. After this funeral c	 	27. Manner of Death		8b. Time of Injury	28c. Inju	and the same of th	-		w injury occurred	,
sior	Attending r death. ector: Atterby the fune	catic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2 1				
Division	or Att after de Direct	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stree	et, factory, office		28f.	City or Town		Rural Route Number,
	spitei ours a nerel l		29a. Certifier Decertifying Physic	ian: To the best of my knowl	ledge, death	occurred at the t	ime, date an	d place, and	due to the ca	use(s) and manner	as stated.
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the r	Medical	(Check only 2 Medical Exemine one)	r: On the basis of examinatio and manner stated.	n and/or inve	estigation, in my	opinion, dea	th occurred a	at the time, da	ite and place, and di	ue to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	4. 0		29c Licen		G		d. Date signed (Mo	
•			* Komme Magne (1			1 1 6	3550	1		leb 25,	WUS
	10		30. Name and address of person who com	pleted cause of death (Item 2	23a) (Type, P	Print)	d 45	M. A	WD 3/1	201	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	rθ /	DATE TIN	TONE !	Ary	W/ W/	201	
	Regist		MAR 0 3 2005	House B.	400						

ANN MCMILL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Day **Physician** 12.51 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SAMARITAN HOSPITAL GIDOL 7. Age (In yes. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign County) 16. Sex **Funeral** Days Hours 1□M 2D Director Usual Residence of Decedent the Maryland 10d, Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examiner must be rediffed at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 100 death with Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Extra 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 's Name (First Be Informant's Name/Relationship (Type) 19b. Mailing Address (3t) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 DRemoval from State 'A □ Donation 5 □ Other (Specify) 22 Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hrs SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of, Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day jo in the past 12 months? Month Year 5 Other (specify) signed by the at d be detached for Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 1 V85 2 □ No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed death? 1 ☐ Yes 2 ☐ No 1 Yes 2 1 NO the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA 1 Impatient 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Hospital or Attending P. 24 hours after death.
 Funeral Director: After t After t Certification: 1 (Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD RES 000 23 05

State Registrar ZEEBA

LOCE

RAVEN BLUD

BALTI MORE - MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

MATHE

601

egistrar's Signature

			FOI	partment of Health and Mental Hy ertificate of Death	giene Reg. No. 005	07122
	Physic	ian	1. Decedent's Name (First, Middle, Last) Donald Quentin Mohr	2. Date of De Month Februal	cy 27, 2005	3. Time of Death 5:55 A M
	/Med Exam		4a. Facility Name (If not institution, give street and number) Gilcrest Center @ GBMC	4b. City, Town, or Location of Death TOWSON	4c. County of Deal Baltim	th
	Funera Director		5. Social Security Number 217-01-4181 6. Sex 1 ☑ M 2 ☐ F 86 Yrs.	Months Days Hours Min. (Month, Da		thplace (State or Foreign ountry) 1land
	9		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	the Mar 28a-f sh	Director	Maryland Baltimore Middle 10e. Street and Number	River	10g. Citizen of What Co	1 Yes 2 No
	h with		109 Wampler Rd.	21220	USA	·
	ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland t Health and Mental Hygiene. Item 27 is marked other then "natural; or Items 23s or 28s-1 show other traumatic event, the Madical Examiliat: set the notilitied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never in U.S. 1: Armed Forces? 1 Never in U.S. If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 No Specify:		
	Maryland 21215-0036 at 2 should be filed within 72 hours aft this and Mental Hygiene. The marked other then "natural", or transmatic event, the Madical Expert transmatic event, the Madical Expert.	Completed	15. Decedent's Education (Specify only highest grade completed) (Gillife Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired)	16b. Kind of Business	
	2 21 iled wi rygien ther th		17. Father's Name (First, Middle, Last)	trical Engineer 18. Mother's Name (First, Middle	Naval Shi	pyard
	lanc	To Be	Arthur J. Mohr		Smith	
	Aary 2 shou and h 1s mai	-	Nescon	ailing Address (Street and Number or Rural Route Numb	CONTROL SERVICE CONTROL	Zip Code)
	re, N 1 and Health tem 27		Denise D. Miller - Daughter 110: 20a. Method of Disposition 20b. Place of Dis	5 Janice Ct., Joppe, Mary sposition (Name of Pate Place)	and 21085 20c. Location - City or	Town, State
	Pages nent of ent: If I		1 Buriai 2 Ni Cremation 3 Bemoval from State		Towson, Mar	ryland
Am	Baltimore, Mipore, Mipore, Miporenit. Pages 1 and 2 Department of Health a Importeni: If Item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	Accomas Funeral Home 1317 Cokesbury Road, Abing	gdon, Maryla	
12	Physician		23a. Part it is the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		rrest,	Approximate Interval Between Onset and Death
P. 3	/Medica Examine	_	resulting in death) Due to (or as a consequence of): Sequentially list conditions, b. CLPEGOVAS CMC	lon accident		dous
3	D =	luer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	A COLOR OF THE PROPERTY OF THE		7
1/cop	8760, cate be executed chysician and the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last C			
2xpirest	Box 6 ath certifi	Physician/Medical		3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of de Month	livery Day Year
hR	ords, P.O. I requires that the de een signed by the a rould be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the	o one onlying out to o great in the care	tobacco use contribute to	o the cause of death?
5	as b	Completed		24a. Wa auto peri 1 🗆 Yes	psy prior to death?	utopsy findings available completion of cause of
8	of Vital Physiclen: T this certificat	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only		
000	on of sing Phys	tlon: To	1 Yes 2 No lossification 1 Inpatient 2 ER/Outpat 27. Manner of Ceath 1 Acceptural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury (Month, Day Year)	e of 28c. Injury at 28d. Describe	idence 6 Other (Spe how injury occurred	cify)VØ3P(CC
Q	Division of To the Hospital or Attending F Within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location City or To	(Street and Number or River, State)	ural Route Number,
	he Hospit in 24 hour he Funera pletely filk	Medical	29a. Certifier Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) American Physician: To the best of my knowledge, de (Check only one) American Physician: To the best of my knowledge, de (Check only one) American Physician: To the best of my knowledge, de (Check only one) American Physician: To the best of my knowledge, de (Check only one) American Physician: To the best of my knowledge, de (Check only one) American Physician: To the best of my knowledge, de (Check only one) American Physician: To the best of my knowledge, de (Check only one) American Physician: To the best of my knowledge, de (Check only one) American Physician: To the best of my knowledge, de (Check only one) American Physician: To the best of examination and/or and manner stated.	r investigation, in my opinion, death occurred at the time	, date and place, and due	o to the cause(s)
	To t With To t	Σ	29b. Signature and title of certifier	29c. License number DSSSO3	29d. Date signed (Mont	* -
	18		30. Name and address of person who completed cause of death (Item, 23a) (Type And William) (I	DS8303 : pe, Print) Clove, St Bulkn	som som	1204
	. ()	tate trar	/31. Date filed (Month Par Year) 3 2005 32. Jegistrar's Signature	field!		

		For Stete Registrer	State of Maryland	/ Depa		lealth and N	lental Hygi	•	5 07123
Physicia /Medica		Decedent's Name (First, Middle, La	Frank	Мc	New, Jr.		2. Date of Death Month Februar	Day Ye	
Examine	er	4a. Facility Name (If not institution, giv Harford Memoria			Havre	r Location of Death De Grace		4c. County of D	Death rd Co.
Funeral Director		5. Social Security Number 6. S 230-30-4395	ex 7. Age (In yrs. last 75	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 5,	Year)	Birthplace (State or Foreign Country) irginia
	Funeral Director	10a. State 10b. County Maryland Ba 10e. Street and Number 7616 Chestnut 11. Marital Status	10c. City, To ltimore Street 12. Was Decedent Ever in U.S.		10f. Zip Code	Ft. Ho 21052 Ilispanic Origin? (Span, Mexican, Puerto	10		10d. Inside City Limits 1 □ Yes 2 ☒ No t Country? States American Indian,
urs efter	þ	1 Never Married 25 Married 3 Widowed 4 Divorced	Armed Forces? 1- Yes 2 □ No If Yes, Give Year or Dates:	i	If Yes, specify Cuba 1 ☐ Yes 25€ No	Specify:	Rićan, etc.)	Black, V	White, etc. White
J within 72 hours efter jiene. r then "natural, or ite	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give life.	DO NOT use retire	during most of work	sing	6b. Kind of Busin Steel I:	,
TO 100 100 100 100 100 100 100 100 100 10	To Be Co	8 Years 17 Father's Name (First, Middle, Last) Frank McNew, Sr		nea	vy nquipi		e (First, Middle, M		ndustry
permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If itam 27 is marked othe eny injury or other traumatic event, once.	-	19a. Informant's Name/Relationship (Ricky McNew, Sr 20a. Method of Disposition 1 Burial 25 cremation 3 5 4 Donation 5 Other (Specification 2) 21. Signature of Funeral Service Licer	Son 20b. Place cemes 20b. Place 12b. P	743 of Dispostery, cres top	8 Bayfron estion (Name of matory or other place Service (2. Name and Addre	ce) 3/1	Ed emere Date 2	Maryla Oc. Location · City Towsort	and 21219
Physician /Medical Examiner		23a. Part1. Elter the disease, or complete, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Done cause on each line. a	o not ent		g, such as cardiac		st,	Approximate Interval Between Onset and Death
ysicie	Ilcai Examiner	Sequentially list conditions, if any, leading to liminediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. NULT Due to (or as a consequence of the consequ	ce of):	la Cri	Poplin try	inia Ineone		
I ne law requires that the death certificate it the has been signed by the attending physioage 2 should be detached for use as the t	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ath 3[Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
w requires that it is been signed by should be detact	þ	Part II. Other significant conditions of	ontributing to death but not resultin	•	nderlying cause giv	en in Part I.			e to the cause of death? Probably 4 Onknown
	Completed						24a. Was an autopsy performe	prior	
ng Pnysicu	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	(Month, Day Year)	b. Time of Injury	f 28c. Injun Wor M 1	er: 4 □ Nursing Ho	h (Check only one ome 5 Residen 28d. Describe how	ce 6 Other (5	
nospiral or Attending 24 hours effer death. Funerel Director: After itely filled in by the fune		4 Homicide determined	building, etc. (Specify)			no data and nin-	City or Town,	State)	r Aural Route Number,
To the Hospital of Attending Physitin 24 hours effer death. To the Funerel Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Certifying Ph 2 → Medical Exar	ysicien: To the best of my knowled inner: On the basis of examination and manner stated.	age, deatl	h occurred at the tin vestigation, in my o	pinion, death occur	red at the time, dat	ise(s) and manne e and place, and d. Date signed (M	due to the cause(s)
k (30. Name and address of person who		a) (Type.	Print))202!		2	25/07
Stat	to.	MAD 03 2005	32. Registrar's Signature	♀.	Uniona	ve, lea	preporu	Le, MD	21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 18&Unpend Item 23a&27/11/20atmen/CB64t/3-23-05 tas Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27, 2005 2005 FEB. **Physician** 0650 A M ALLAN MEYERS JAY /Medical 4a. Facility Name (If not institution, give street and number)
37 MAINVIEW COURT 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 MD 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 0470771953 51 217-54-2260 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-1 show free must be notified at 1 ☐ Yes 2 ☐ No Director RANDALLSTOWN MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 37 MAINVIEW COURT 21133 U.S.A. Items 23e Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Land Mental Hygiene.

Tals marked other the strains of trains. 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) X-RAY TECHNICIAN HEALTHCARE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other treumatic evones. **MEYERS** BERNICE Godfrey **MEYERS** MARTIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 MAINVIEW COURT RANDALLSTOWN, MD 21133 LAURIE MEYERS / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State B'NAI ISRAEL CEMETERY 3/2/2005 BALTIMORE, MD ^ 4 □ Donation — 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Tocar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. Hypertensive atherosclerotic cardiovascular disease disease or condition resulting in death) /Medical-Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events nding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physiclan/Medical the the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1X Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specity) AT SCENE Hospital: 1 XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death After Injury 5 Pending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation s after death completely filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funeral I To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME FEB. 28, 2005 -30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 THEODORE MIKE

31. Date filed (Month, Day, Year) MAR 0 3

32. Acistrar's Signature

2005

Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Qate of Death 1. Decedent's Name (First, Middle, Last) Month FFB 28 pay **Physician** 2005 Augusta Marx 9:00 A /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Pasadena Anne Arundel 8132 Pine Hurst Harbor Way If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. 96 Director 082-34-7892 JULY 7, New York Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "naturel", or items 23s or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Pinellas St. Petersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33705 USA 4635 Neptune Drive death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 15 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importment if tiem 27 is marked other then "naturel", or iten any injury or other traumatic event, It a Medical Examinations. Black, White, etc 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) New York City Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Otto Franz Mary Dietz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8132 Pine Hurst Harbor Way, Pasadena, MD 21122 Joan Lander - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State ** 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Wash. Crem. 3/2/2005 Laurel, MD 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) congestive heart **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a

To the Funerel I

completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of ceptities D41816 m D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(b 6 x = 14), Pholosomp 137 Old Solomon's Island Rd. Annapolis, MD 21401 h Charles W. Pha 15000 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 0 3 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Nelson 1110 AM 28 2005 uzender /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Date Gienera 7. Age (In yrs. last birthday) NIA Daltimor Vland 9. Birthplace (State or Foreign Social Security Number 6 Sax **Funeral** Days 49 Hours 1 M 2 F 214-62-8069 Director Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count 10a State other traumatic event, the Medical Exaction found by notified at 1 Yes 2 No Director MD NIA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 21217 USA Itams 23a 1334 Division Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. (EISON, LUZEN) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No "natural', or Specify: Specify: Black It Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Nursing Aid Home Nursing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nathaniel Nelson NoKomis Woodham 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other train once. Balto mo 3000 Towanda Ave. 21315 Woodham Nelson Notomis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State • 4 □ Donation 5 Ø Other (Specify) Catons Ville, mo Crematory Metro Sign have of Fureral Service Ucenser 22. Name and Address of Facility Gary P. March Flx 270 Fredhilton Pass Balto mo 21229 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one caus in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jmonia Pnysician disease or condition resulting in death) /Medical Immune Deficiency Syndar Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consuluence of): Examiner that the death certificate be executed Due to (or as a consequence of): the attending physician a hed for use as the burial-Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4□Pregnant at time of death P.O. þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by The law requires cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 PNo 1 Yes Division of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Impatient ို 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending death. 1 🗌 Yes 2 No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 👺 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Berodatchers who completed cause of death (Item 23a) (Type, Print)) 30. Name and address of person datcheva arylanc 31. Date filed (Month, Day,

Registrar

			1 - For State Registrar	State	of Maryla		artment rtificate			nd Mer	ntal Hygie Reg	71115	07128
			Decedent's Name (First, Middle,	Last)						2.	Date of Death		3. Time of Death
	Physici /Medic		Betty Sue Oak	lev						М	Month arch 1	Day Yee 2005	4:00 p ^M
	Examin		4a. Facility Name (If not institution,	give street and no	ımber)		4b. City, T	own, or	Location of	Death		4c. County of D	
н			2013 Kenny Court	t			Edge		l			Harford	l
	Funeral			6. Sex 1 □ M 2 🔀 F		rs. last birthday)	If Under 1 Months	Days	If Under 2	Min. 8.	Date of Birth (Month, Day, Yo ept29, 1	9. I	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		68	Yrs.				S	ept29,1	936 No	orth Carolina
	/łand		10a. State 10b. County		10c. (City, Town or Lo	cation						10d. Inside City Limits
	Many f sh	ţ	Maryland Harford	f	E	dgewood							1 ☐ Yes 2☐ No
	r 28a	Director	10e. Street and Number				10f. Zip (Code			10g	. Citizen of What	Country?
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	ems	Funeral	11. Marital Status	12. Was Dec Armed F	edent Ever in orces?	U.S. 13.	Was Decede	ent of Hi	spanic Origi n, Mexican,	in? (Specify Puerto Ric	y Yes or No- an, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
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ن د د د	J within 72 hours after death with the Marylan Jiene. r then "natural", or Items 23a or 28a-f show the Medical Exaction intest be multiled at		3 Novidowed 4 ☐ Divorced 15. Decedent*	Year or I	Jates:	16a Dece	dent's Usual	Occupa	ation		16	b. Kind of Busine	White
Ċ	in 72 n "na fedic	Completed	(Specify only highest	t grade completed		(Give	kind of work	done d	luring most of	of working	10	b. Kind of Busine	samoustry
7	r the	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	Homem	aker					Own Home	
and	be filed Ital Hygie of other	Bec	17. Father's Name (First, Middle, L	ast)					18. Mother	's Name (F	irst, Middle, Mai		
<u> </u>		To E	Johnny Richards						Doll	y Mae	Fletch	er	
Mar	C		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address ((Street a	ın <i>d Number</i>	or Rural R	oute Number, C	ity or Town, State	a, Zip Code)
a) ≥	s 1 and of Health Item 27 other tr		Laura Marie Peac	ce (Daugh		2013			rt, E	djewo		yland 21	
	Pages 1 nent of H nnt: If Ite iry or ot		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation		State	cemetery, crei	natory or oth	her place				. Location - City	
аппо	it. Pa		* 4 □ Donation 5 □ Other (Sp 21 Signature of Funeral Service L		Но		1 Mem.				,2005 B	altimore	, Maryland
n n	permit. Pages Department of I Importent: If Its any injury or o	-	2. Signature of Pulled at Service C	Certago	\geq			Br	uzdzi	nski 1		Home, P	
			23a: Part1. Enter la disease, or o shock, or to fit failure. List o	complications that	caused the de	eath. Do not ent	er the mode	of dying	Faste: g, such as ca	rn Ave	enue, Es	ssex, Ma	ryland 21221 Approximate
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	Examiner			. (0	xea							mosts
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	ocuted nd transi	Examiner	that initiated events	с									
Š	oe execian a	al Ex	resulting in death) Last	Due to	(or as a cons	equence of):							
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XO	w requires that the death certific been signed by the attending p should be detached for use as	lan/Me	IF FEMALE:	23c. If yes, or	atcome of preg	nancy						23d. Date of	delivery
Ď	death atter	iciar	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Fe nant at time of	etal death 3	Ectopic pre Other (spe					Month	Day Year
j.	t the c achec	hysi	1 ☐ Yes 2 XNo 9 ☐ Unknown	9□ Unki	nown								
, Č	s than	by P	Part II. Other significant condition	ns contributing to	death but not r	esulting in the u	nderlying ca	use give	en in Part I.		23e. Did tobac	co use contribute	to the cause of death?
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ວ	> _ C &	ompleted			· · · · · · · · · · · · · · · · · · ·						24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
	ilcian: The lav certificate has rector, page 2	Соп									performed 1 ☐ Yes 2.2		? es 2□ No
<u> </u>	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	I le seitel:				0.1		of Death (C	heck only one)		
	Physic this c	은	1 ☐ Yes 2 XNo			☐ ER/Outpatier			4 LI Nurs	-		e 6 Other (S	pecify)
	Jing f	on	27. Manner of Death 1 ★Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury	M 28	c. Injury Work	ant (? /es 2.∐N		. Describe how	injury occurred	
VISION	death death ctor; y the	ficat	2 Accident investig. 3 Suicide 6 Could n	ot be	e of Injury - At	home, farm, str			.03 2	_	Location (Stree	t and Number or	Rural Route Number,
$\frac{2}{5}$	after after Dire	Certification;	4 Homicide determi		ling, etc. (Spe		, ,				City or Town, S		,
	papite hours inere	a O	29a. Certifier 1 Certifying	Physician: To th	e best of my k	nowledge, deat	occurred a	t the tim	e, date and	place, and	due to the caus	e(s) and manner	as stated.
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edicai	(Check only 2 Medical E	xaminer: On the and ma	pasis of exami oner stated.	nation and/or in	vestigation, i	in my op	oinion, death	n occurred a	at the time, date	and place, and d	ue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	0	/			_	number		0	Date signed (Mo	
	/		Celler	d. 0	m, u	a D	M	D-	D-00	0187	179 M	raich 2	2,2005
	13		30. Name and address of person v	who completed cau	ise of death (It	em 23a) (Type,	Print)	ORD	e Fa	elsta	en MI	2/0	47
	Sta Registr	_	31. Date filed (Month, Day, Year)	who completed cate Sun M D 32.	Registrar's Sig	nature	Goal						
			- MAK V	4 - 4444	7		-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Year **Physician** Marzh 10:05AM 2005 **JACK LEE PATTERSON** /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL NORTH ARUNDEL HOSPITAL GLEN BURNIE 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** MD 1956 48 AUG 8. Director 217.74.6914 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f show the Mudical Exertiner must be notified at 1 ☐ Yes 2 ☐ No Director ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21061 7849 CINDY DR Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married ŏ 2□ No XX 1 🗌 Yes Specify: þ 3 Widowed 4 Divorced WHITE Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION LABORER 10 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **EUNICE WAGNER** RAYMOND PATTERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7749 CENTRAL AVE PASADENA, MD 21122 GERALDINE AUBURGER SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial *** Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ALL COUNTY CREMATORY 3.3.2005 SYKESVILLE, MD 21. Signature of Funeral Service Licensee FINK FUNERAL HOME, P.A. K. GREGORY FINK MO1148 426 CRAIN HWY SW GLEN BURNIE, MD21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EMI 45 /Medical Due to (or as a consequence of) Examiner Quelka. DNEUMONI Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (*r as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of). Box 68760. attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check on one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA Certification; To 2 ER/Outpatient this te of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 1 2005 30. Name and a press of person who completed cause of death (Item 23a) (Type, Print) anoka Dugyan Burne. 32. Register's Signature 31. Date filed (Month, Day, Year) State Registrar

State Registrar Registrar's Signature

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	Physici	an	1. Decedent's Name (First, Middle,	Last)					Date of Death Month	Day Year	3. Time of Death
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	E		Greater Baltimo		al Cent		Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltimo	
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	with Ba or		427 Piney Hill	Dood			10f. Zip Code 21152)	10g.	Citizen of What Co	untry?
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Palm.	000		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from S	State 20b. P	lace of Dispo emetery, cren	sition (Name of natory or other plac	ce) 3/3	705 ^{20c.}	Location - City or	Town, State
E C	permit. Pag Department Important: I any injury o		'4 □ Donation 5 □ Other (Spe		Dula	ney V	alley Mem	n. Gardens	i Ti	lmonium, 1	Maryland
Bal	permit. Pag Department important: I any injury o once.		2) Signature of Funeral Service (Inchine III) Michael J. F	lagle	lage	L Le 10	Mame and Addre	eral Home nia Road.	of Dulane	y Valley Marylan	Inc. d 21093
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Вох	eath certific attending p	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out	come of pregna		Ectopic pregnancy	/		23d. Date of deliv	•
O.	at the dea by the al	Physician/M	1 Yes 2 No	4☐Pregn. 9☐ Unkno	ant at time of de		Other (specify)			Month	Day Year
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ž	or Ati fter d Direct in by	rtifi	3 Suicide 6 Could no 4 Homicide determin	28e. Place	of Injury - At ho ng, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Street City or Town, St.	and Number or Rui ate)	al Route Number,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, it	edical	29a. Certifier (Check only one) Certifying 2 Medical Ex	aminer: On the ba and manr	isis of examinat	wiedge, death ion and/or inv	occurred at the ting restigation, in my o	ne, date and place, a pinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as and due to	stated. to the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifier				29c. Licens		29d. [Date signed (Month,	Day, Year)
	_		Ma	~~	Ch		195	8305	Fe	bruary	28 2005
	20		30. Name and address of person with ARNA CHARM	CS W	e of death (Item	23a) (Type,	Print)	Bultimore	mo 21	64	28 2005
3	Sta	te	31. Date filed (Month, Day, Year)	105 A	egistrar's Sign	уге	Les .				- 11-

					State of	Marylar		irtment of <i>tificate o</i>		and Me		giene Reg. No. 2 (005	07132
	Physici	an	1. Decedent's Name (First, Mic		1)						2. Date of De Month		Year	3. Time of Death
1	/Medic		DOROTHY	P.			TRZUS	<1	4 65 +		MARCH	02	2005	7:00 AM
	Examin	er	4a Fecility Name (If not institute 3437 YORK)		street and num	ber)			BALTI		ation of Deatl		ty of Deeth	D.E.
	Funeral		5. Social Security Number	6. Se	× 7	. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under:		8. Date of Bir (Month, Da		TIMOI 9. Bjrthp	K.E. place (State or Foreign ntry)
×	Director		200-09-0471	10	□M 2129F	8	6 Yrs.	Months Day	s Hours	Min.	1/24	/19	PENI	NSYLVANIA
	pur *		Usual Residence of Decedent 10a. State 10b. Cour	ab.		10c Ci	ty, Town or Lo	ation						0d. Inside City Limits
	Aaryla f sho	5		1	4ODE	100. 01								1 ☐ Yes 2 🗷 No
	28a	ž	MD BA	LIIN	4ORE		BALI	I MORE				10g. Citizen of	What Cour	ntry?
	h with	Funeral Director	3437 YORKWA	Y				212	222				USA	
	deet and a	ner	11. Maritel Status		12. Was Deced	ent Ever in U	J,S. 13. V	Vas Decedent o Yes, specify Co	f Hispenic Orio	gin? (Spec	cify Yes or No	- 14. Ra	ice - Americ	
20	within 72 hours after deeth with the Maryland ana. than "natural", or items 23e or 28e-f show he Medical Examiner must be notified at		1 ☐ Never Married 2 ☑ M 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes 2 If Yes, Give Year or Dat	⊠ No		☐ Yes 20% N		, , , , , , , , , , , , , , , , , , , ,	, O(0.)	Spec	ify:	
Maryland 21215-0020	"natural", adical Exe	Completed by	15. Deced	ent's Edu	cetion		16a. Deced	ent's Usual Occ	upation			16b. Kind of I	WH 3	
218	within 7 ana. than "n	De l	(Specify only high	Ť	le completed) College (1-4	lor 5+)	life. D	kind of work dor OO NOT use reti	e during most red)	of working	9			
121	filed with Hygiana. wher ther	S	12		0		ELEC	TRONIC						MARTIN
and	P P P	Be	17. Father's Neme (First, Middle LESLIE BA		2				18. Mothe	r's Name	(First, Middle,	Maiden Suma		
ĮŽ	2 should end Man is marks aumatic	ဥ	19a. Informant's Name/Relatio			-	19b Mailin	g Address (Stre	et and Numbe	r or Rural	Route Numb	PERK		Code
	교육자후	- 1	MR. WALTER				1:	YORKWA				MT) 21	222	0000)
ore,	- I F F		20a. Method of Disposition			1	Place of Dispos	sition (Name of patory or other p			Date	20c. Location	- City or To	wn, State
im	Pages nent of sent: If its ury or o		1 ⊠ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other			ST	. STAN	IŚLAUŚ	CEME	. 3/	5/05	BALTI	MORE,	, MD.
Baltimore,	parmit. Page Department Important: if any Injury or once.		21. Signature of Funeral Service	e (Acens	ee /	· ·	α K ² A	CZORÓW	ress of Facility	UNER	AL HO	ME P.	Α.	
ш	20 = 30		Lugar	1	Cost	€ /	,	01 DUN						21222
	4 22		23a. Part1. Enter the disease shock, or heart failure.	or complist only o	lications that cau ne cause on eac	used the deat ch line.	th. Do not ente	r the mode of d	ying, such as	cardiac or	respiratory a	rrest,	1	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final										1	Onset and Death
	Examiner		disease or condition resulting in death)	1	a. PHE	MONI							1	3 DAYS
		ner				Due to (or as a consequ	uence of):					ļ	
V	ificata be executed g physician and es the burial-transit	Examiner	Sequentially list conditions,		b	Due to (d	or as a consequ	uence of):			-			
60,	be exe cian a burial-	al Ey	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events	Į,	c								1	
68760,	physicata physicata	edical	that initieted events resulting in death) Last			Due to (c	or as e consequ	ence of):						
Box (eath certif attending I for use et	Me		L,	d								-	
	The law requires that the death certate has been signed by the attendin page 2 should be detached for use	Physician/M	Part II. Other eignificant condi	tione cor	ntributing to dea	th but not res	sulting in the un	derivino cause	iven in Part I.		23b. Did	tobacco use c	ontribute to	the cause of death?
P.0	res that the designed by the a	Phys	24. 7					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1 🗆	_	3 ☐ Prob	
	gne be c	5	DEPRESSION	•										
Records,	v require been si should I	Completed	HYPERTENSI	200							24a. Was perfo	an autopsy rmed?	ava	ere autopsy findings ailable prior to mpletion of cause
Rec	e law has b	dm									200	- 4	of o	death?
<u>a</u>			25. Was case referred to media	cal					DC Disease	of Dooth	(Check only o		1	Yes 2 No
of Vital		To Be	examiner? 1 ☐ Yes 2 ☒ No	+	Hospital:	patient 2	ER/Outpatient	3□ DOA C	Whor:			dence 6 ⊡Ot	her (Specifi	v)
0 4	ig Phys ter this neral d	ä	27. Manner of Death 1. Natural 5 □ Pend	dina	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. In				now injury occu		
sio	Attending ir death. actor: After by the fune	catic		stigation					□Yes 2□N					
Division	or At aftar d Direct In by	Certification:		mined	28e. Plece o building	f Injury - At h , etc. (Specif	ome, farm, stre fy)	et, factory, offic	₿	28	3f. Location (3 City or Tov	Street and Num vn, State)	ber or Rura	l Route Number,
	apital	N N	29a. Certifier 1 → Certify	ing Phy	sician: To the b	est of my kno	włedge, death	occurred at the	time, date and	d place, an	d due to the	cause(s) and m	nanner as st	ated.
	in 24 l	edicai	(Check only 2 Medical one)	si Exami	ner: On the bas and manne	is of examina r stated.	ition end/or inv	estigation, in my	opinion, deat	h occurred	d at the time,	date and place	, and due to	the cause(s)
_	To the Hospital or Attending Phys within 24 hours aftar death. To the Funeral Director: After this completely filled in by tha funeral di	Σ	29b. Signature end title of certif	ier //	Ú	1		29c. Lice	nse number			29d. Date sign	ed (Month, I	Day, Year)
			Jameta	11	nost				36203	2		MARCH	02,	2005
	10		30. Name and address of person		ompleted cause	of death (Iter	n 23e) (Type, F	Print) VIEW CIRC	- A	1.	~ A~ "	10 -1-	n 11	
	Sta	to.	1) enriter- Hayasi 31. Date filed (Month Day, Yes		32. Reg	jistrar's Şigna	ature	VIEW CIVE	LE U/	TLTIM	OKE, N	(n x13	18 Y	
-	Registr	ar	MAR U3 2	CUU	Release	J.	ature force							

			1- State of Maryland / Depar Registrar Certi	tment of Health and N <i>ificate of Death</i>		ene 005	07133
	Dhumini		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Eller Parks		Feb 2	6 2005	7:40 A M
}	Examin	er		b. City, Town, or Location of Death		4c. County of Death	
			University of manylad m. diral Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	NA O Rintha	Jane (State of Familia
	Funeral Director			Months Days Hours Min.	March 1,	1925 Mary	lace (State or Foreign itry)
	ס		Usual Residence of Decedent		FIGURE CIT I	1)25 FELLY	Laria
	anylar show	_	10a. State 10b. County 10c. City, Town or Loca	tion		1	Od. Inside City Limits
	ha M 28a-f	ecto	Maryland Harford Abingdon				1 ☐ Yes 2 X No
	with t	Dir	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cour	try?
	ms 23	Funeral Director	3105 Abingdon Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	21009 as Decedent of Hispanic Origin? (Spreas, specify Cuban, Mexican, Puerto	pecify Yes or No-	USA 14. Race - Americ	an Indian,
9	aftar or ita		1 Never Married 2 Married 1 Yes 2X No _		Rican, etc.)	Black, White,	etc.
8	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23a or 28a-f show ent. The Medical Examinat must be notified at	d by	3 Wildowed 4 □ Divorced Year or Dates:	Yes 🌠 No Specify:		Specify: Wh:	ite
<u>7</u>	n 72 ł	Completed	(Specify only highest grade completed) (Give kir	nt's Usual Occupation ad of work done during most of work NOT use retired)	king 16	3b. Kind of Business/Ind	lustry
712	I withi iene. r than	ошь	Elementary/Secondary (0-12) College (1-4or 5+)	ctional Teacher'	s Aida D	ublic Educ	ation
ğ	a filec Il Hyg otha vant.	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		acton
<u> a</u>	should ba ind Mental markad o umatic eve	To E	William Benjamin Rinehart	Emma	Frederic	ka Bear	rsch
Maryland 21215-0036	2 sho and is me	i j	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rui	al Route Number, (City or Town, State, Zip	Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f show or other treumatic event. The Medical Examiner must be notified at		Cheryl Parks-Weidley - Daughter 9070 I	Waltham Woods Ro			
ltimore,	Pages nent of H int: If ite iry or of		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cremation	tory or other place)		c. Location - City or To	
	parmit. Page Department of Important: If any injury or once.			Mem. Gardens 3-0. Name and Address of Facility Marketing Marketin		llston, Mai neral Home	
Ba	Dep.		4.1601	17 Cokesbury Roa			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arres	t.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a	farction			Onset and Death
	/Medical Examiner		Due tylor as a consequence of):				
	100	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	cuted	Examiner	cause. Enter Underlying that initiated events c.				
Ö,	ificate be executed g physician and as the buriat-transit		resulting in death) Last Due to (or as a consequence of):				
68760	ficate b	edicai	d				
_			IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	D/
Box	death e atter	Physician/M	in the past 12 months? 1	ctopic pregnancy hther (specify)			Day Year
P. O.	t the by the tache	hys	9 ☐ Unknown				
Ś	res that the de signed by the a be detached f	by F	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		cco use contribute to th	
ord	w requir been si should		Esophageal Career		1 Tes	2. No 3 □ Proba	ably 4 Unknown
ec	est UD out	ompieted			24a. Was an autopsy	prior to con	osy findings available inpletion of cause of
Vital Record		O			performa 1 ☐ Yes 2	d? death? 1 ☐ Yes	2 2 No
Ĭ	aiciar certif irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Impatient 2 ☐ ER/Outpatient	Othor	h (Check only one)		
o	Attanding Phyaician: r death. actor, After this certifics by the funeral director, I	-	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	28d. Describe how	ce 6 Other (Specify injury occurred	,
0	ath. rr; Aft	atio	Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of	l or Atta after de Diracto	ertification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	28f. Location (Stree City or Town,	et and Number or Rural State)	Route Number,
	urs af	O					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After thi completely filled in by the funeral.	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death or (Check only one) Certifying Physicien: To the best of my knowledge, death or (Check only one)	ccurred at the time, date and place, stigation, in my opinion, death occur	and due to the causered at the time, date	se(s) and manner as sta and place, and due to	ited. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifie	29c. License number		. Date signed (Month, L	
•			1/16 th 11/10	P18547	Fe	6,263	1005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	nt)	1		
	Sta	to	1. ATINCH /VO(Ax, 11) ad Jouth ()1 31. Date filed (Month Par, Yearh 32 registrar's Signature	Rene ST BA	timole,	mp	
	Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri Matthew Nolaw, MD 22 South Gr 31. Date filed (Month Par Yearl) 2005 32 Jegistrar's Signature 34 Jegistrar's Signature	467			

VETT 05-01535 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 19a per fh 8841 3-29-05 vt

State of Maryland / Department of Health and Mental Hygiene

1- For Unpend Item 23a, 27, 28a-f per me 6841 3-15-05 tas

Certificate of Death

Reg. No. 0 5 Mary-Ann Richards 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 28, 2005 **Physician** 13:10 Mary-Ann Richards /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center **Baltimore** Towson 7. Age (In yrs. last birthday) 56 yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) MAY 12, 19 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F 1948 Director 301-48-8701 Ohio Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner reset be notified at 1 Yes 2 No Director Maryland | Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 8434 Apt. A Charles Valley Court or items 23a 21204 death Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or item 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Fictional Writer other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John T. McCormick ပ္ Hazel Ann Datey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hollie 3819 Jefferson Street Austin, TX 78731 -Marie Richards/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō <u>=</u> ö 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Metro Crematory, Inc. ¹ 4 □ Donation 5 □ Other (Specify) 3/2/05 Baltimore, MD 21. Signature of Funeral Service Licenses Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiomyopathy Complicated by Adbominal Injury /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed **Durial-transit** Due to (or as a consequence of) Box 68760. as the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pg. 1 Tes 2 No 3 Probably 4 Ninknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2 No 24a. Was an 1 Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To 1XYes 2 No 28a. Date of Injury unk 28b. Time of unk 28c. Injury at (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred □Natural 5 Pending 1 Yes 2 No Accident 3 Suicide investigation death Probable fall the within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8434-A Charles Valley Ct. Towson, MD filled in by 4 Homicide Found in residence Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 25 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) The return. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/200

State

ck

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCME

111 Penn Street

March 01, 2005

Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician SEUNARINE RAMBISSOON 4:33 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE JOHNS BAYVIEW HOPKINS BALTIMORE WW If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**M** 2□ F Months 6 Director 213-62-9482 6/08/1928 Trinidad Usual Residence of Decedent deeth with the Marylend show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ust be nutified at Yes 2□No Director Maryland Baltimore 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ tems 23a 1147 Steelton Avenue 21224 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. the Medical Examination filed within 72 hours efter 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Asian-Pacific Baltimore, Maryland 21215-0036 1 ☐ Yes 200No Specify: Completed by 3 Widowed 4 Divorced Islander 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Welder 12 Steel of Health and Mental Hygie fitem 27 is marked other t r other treumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 end 2 should be Lalchan Rambissoon Baboonie Rampersad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Seeta Harracksingh (Daughter) 1610 Williams Avenue, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State to = MXBurial 2 ☐ Cremation 3 ☐ Removal from State 5 ortent: if HollyHill Mem. Gard. March 2,2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) njury perniit. Departn Importe any nju 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Fundral Servic Ligensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in math) Physician PNEUMONIA 6 DITT /Medical Due to (or as a consequence of): Examiner 28 0.4 RUPTURED ABDOMINAL HORTIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 🕍 No Month Day 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENTH FAILURE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed FALLVRE 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? LIVER 2 💢 No 1 Yes 2 No 1 TYes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation Injury efter death. 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospitei within 24 hours e To the Funerel C completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

4940

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

03

31. Date filed (Month, Day, Year)

MD.

RES-000

02/27/2005

Eastern Aue, Baltimore, MD 21224

		1- State of Maryland / Department of Health and Maryland / Department of Health Andrew Maryland / Department of Health Andrew Maryland / Department of Health Andrew Maryland / Department /	Mental Hy	giene 005	07136
Q.		1. Decedent's Name (First, Middle, Last)	2. Date of De	ath Day Year	3. Time of Death
Physic /Med		Jimmie L. Roper	Feb	11 200	
Exam	iner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	ath
		BON SECOURS HOSPITAL BALTIME 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		-	
Funera Directo		286-20-3238 1 N 2 F 78 Yrs. Months Days Hours Min.	8-22-	iy, Year)	rthplace (State or Foreign country)
		Usual Residence of Decedent	10-22-	20 <u>E</u> V	ergreen,AL
tarylan show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Ba-f s	cto	MD Baltimore			1X Yes 2 No
vith th	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
eath	era	2509 Lauretta Ave. 21217 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	north Vac as Na	USA 14. Race - Arr	arian Indian
fter d	Funeral Director	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Wh	
alt, o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: B1	ack
72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	kina	16b. Kind of Busines	s/Industry
ithin han	nple	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	9		
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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23e or 28e-f show aumatic event, I'm Modical Examination or 18 to marked other than 18 marked other 18 marke	J.	Edward Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur			Zin Code)
and 2 sealth ar n 27 ls		Maryum Shabazz 2509 Lauretta Ave.			
s 1 a a d Head itam other		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City o	
Pages nent of I		120 Burlai 2 Ucremation 3 Unemoval from State	6-05	Owings Mi	11. Mp
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health, and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, If a Modical Examinations 1 to nutified at any one.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Date			
	1	Danel L. Hunter 2007 Eastern Ave	-		1231
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death) a. atherosclerotic cardiovas	cular	disease	20 years
/Medica Examine		Due to (or as a consequence of):			
STORY W	Į.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
exec an an rial-tr		resulting in death) Last Due to (or as a consequence of):			
cate be executed obysician and the burial-transit	dical	d			
artifica ing ph	Med	IF FEMALE:			
eath certific attending p	lan/l	23b. Was decedent pregnant in the past 12 months? 1□Live birth 2□Fetal death 3□Ectopic pregnancy		23d. Date of de Month	livery Day Year
the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		ind it.	Day Tou.
res that the digned by the be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
uires uires sign	d by		1 🗆 '	res 2□No 3□P	robably 4 Onknown
w require been sign	lete		24a. Was	an 24b. Were a	utopsy findings available
The lav te has age 2	Completed		autor perfo	prior to death?	completion of cause of
ysicien: The is certificate h	a	25. Was case referred to medical 26. Place of Deat	1 ☐ Yes	2 1 Ye.	2 2 No
Physici this ce al direc	To B	examiner? Hospital:		dence 6 Other (Spe	ecify)
ing Ph Mer th		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	28d. Describe I	now injury occurred	
tending death. tor: After the funer	catl	2 Accident investigation M 1 Yes 2 No			
or Al after of Dirac	ertification;	determined	City or Tov	Street and Number or Fi vn, State)	ural Route Number,
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cause(s) and manner a	e stated
a Ho 24 h a Fur	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time,	date and place, and du	e to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mon	**
		V Madhan MD ANHITIAHSKMI	5871	Feb 14	2005
1)	V Madhan MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VANDANA MADKAN Baltimore VA Medica	4 4	10 N	Greene St
	4	VANDANA MADKAN Baltimore VA Medical 31. Date filed (Month, Day, Year) 32. Registral Signature	all Cer	nter Baltin	nove MOZIZO
S Regis	tate trar	31. Date filed (Month, Day, Year) MAR 0 3 2005			

			1 = For State Registrar	State of M	Maryland		artmen <i>rtificat</i>					giene Rag. No.		071	37
	Physici	an	Decedent's Name (First, Middle,								2. Date of De Month	ath Day	Yea		
	/Medic	al	Margie Robins 4a. Facility Name (If not institution, g		a cl		4h Cihi	Tourn or	Location (of Dogth	FEBRUA		26, 20 County of D	05 12:44	P M
	Examir	er	Saint Joseph	Medical	Center	.~	4D. City,	TOWII, OF		VSON	ı	40.		timore	
	Funeral Director		5. Social Security Number 215-16-7650	. Sex 7. 1 □ M 2 X F	Age (In yrs. las		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)		Birthplace (State of Country)	r Foreign
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	ocation							10d. Inside Cit	v Limite
	Maryli f sho	ō	MD		Balt									1 X Yes	
	r 28a	Director	10e. Street and Number		Darc	TINOL	10f. Zip	Code				10g. Citi	zen of What	Country?	
	th wit	aiD	433 Oxford Ct	•			21	201				US	A		
	er dea	Funeral	11. Marital Status	12. Was Decede Armed Force 1 ☐ Yes 2	nt Ever in U.S.	13.	Was Deced	dent of Hi cify Cuba	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.))-		merican Indian, /hite, etc.	
336	urs aft	by F	1 XNever Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Date			1 🗆 Yes	2XI No	Specify:				Specify: B	lack	
21215-0036	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show edeal Eratulner must be codified at		15. Decedent's			16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of work	ina	16b. Ki	nd of Busine	ss/Industry	
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d 2	filed Hygi ther int, I		2nd 17. Father's Name (First, Middle, La	ist)		Dome	stic	!	18. Mothe	er's Name	e (First, Middle			Homes	
an	ould be Mental arkad o	To Be	Charlie Robin	son							oinson		,		
Maryland	and and sm	_	19a. Informant's Name/Relationship			19b. Maili	ng Address				al Route Numb		r Town, Stat	e, Zip Code)	
	is 1 and 2 of Health item 27 other tra		Denise Chaney	(neice)	20h Bloo	6320	Fal	kir	k Rd		alto.				
Baltimore,	0 0		20a. Method of Disposition 1X Burial 2 □ Cremation 3		ue		osition (Nar matory or o		1					or Town, State	
뜵	permit. Pag Department Important: i any injury o		4 □ Donation 5 □ Other (Special Signature of Euneral Service Li	-	Sac		Hear			3-2-	-05 sley C	Dung	dalk,	MD FH	
B	Departiment of the second of t		1/Oslan	Char							Bal				
			23a. Part I. Enter the disease or coshock, or heart failure cist of	omplications that causely one cause on each	the death.						or respiratory a			Approximate Interval Bety	veen
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a MYOCAR		INFA	RCTI	INC						Onset and D	
	/Medical Examiner		resulting at dealth)	Due to (or ARTERI	as a consequer		r rol	חדת	າບລະເ		D DIE				
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	nd nd transit	Examine	that initiated events	c											
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687	icate physi	edica		d											
) XO	leath certifica attending planding planding planding as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregnanc		⊒Ectopic pr						23d. Date of	delivery	
). B	ne deat the attr	sicia	in the past 12 months? 1 Yes 2 XVo		t at time of deat		Other (sp						Month	Day Y	ear
P.0	that the de ed by the detached		9 ☐ Unknown Part II. Other significant condition	s contributing to deat	h but not resulti	ing in the u	ınderivina c	ause dive	en in Part I		23e, Did t	obacco u	ise contribut	e to the cause of de	eath?
Records,	puires than signed	d by					, , ,				1 🗆	Yes 2	X No 3□	Probably 4 🗆 U	nknown
COI	aw requii s been s 2 should	Completed									24a. Was		24b. Were	autopsy findings a	available
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Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	l III I				Tai		of Deatl	(Check only				
of	S S	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospital: 1 X Inp		VOutpatie	nt 3 DC		4 🗆 140		me 5 Resi 28d. Describe			ipecify)	
ion	Attending Ph r death. ector: After th by the funeral	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of (Month,	Day Year)	Injury	M	8c. Injury Work	k? Yes 2□		200. 2000/100	11011 111101	y occurred		
Division		Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place of	Injury - At home, etc. (Specify)	e, farm, st	reet, factory	/, office			28f. Location (City or To	Street an wn, State	d Number oi)	Rural Route Numb	ber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical (29a. Certifier 1 \(\infty\) Certifying (Check only one) 2 \(\infty\) Medical E	Physician: To the be xaminer: On the basi and manner	s of examination	edge, deat n and/or in	th occurred evestigation	at the tim	ne, date an pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) date and	and manner place, and	as stated. due to the cause(s)	
	To the within To the Comp	×	29b. Signature and title of certifier	1.LN 0			290	. License	e number			29d. Dat	e signed (M	onth, Day, Year)	
•			1000	K IND.			D	307	749			0	1/20	0/05	
	1		30. Name and address of person w	ho completed cause			1								
	St	ate	TAMES I DOVE 31. Date filed (Month, Day 160)	0 3 2005 Aeg	is the Color	DSI /	R		TO	402k	, MAR	YLAN	ID 21:	2014	
	Regist		AstL),	•			•								

)		•	For State Registrar	State of Mary		artment of		and Mental H	ygiene Reg. Ne.	005	071	38
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Marnette Flora	Rohrbach				2. Date of D Month Februa	Day	, 2005	3. Time of 8:45	Death P M
I	Examin		4a. Facility Name (If not institution, give s Genesis Nursing CX 5. Social Security Number 6. Sex	tr Loch		Bal	n, or Location of timore ar If Under:			County of Death Baltimo		
	Funeral Director			M 200 F 9 (yrs. last birthday) Yrs.	Months Da			Dav. Year)	Cou	place (State ontry) YLand	r Foreign
	e Marylan 8a-f show	ctor	10a. State 10b. County Maryland Baltimore		c. City, Town or Lo	Baltimo	re				10d. Inside Ci 1 ☐ Yes	•
	s 23a or 2	eral Dire	3303 Willoughby R	Road	- LIC 140	10f. Zip Cod	21234			en of What Cou	•	
980	ours efter d rai', or Item Examinar	by Fun	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		If Yes, specify C		gin? (Specify Yes or N , Puerto Rican, etc.)		4. Race - Ameri Black, White, Specify: Wh		
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours efter deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinat must be notified at	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re & Rephe	ne during most ired)			d of Business/In	ĺ	
land 2	should be filed nd Mental Hygir marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) John I. Cusic	100-000 - 000	Caucan	5 Repre	18. Mothe	r's Name (First, Middle tie Belle	le, Maiden S	Sumame)	ecuix	9
	and 2 shot ealth and N m 27 is ma		19a. Informant's Name/Relationship (Type Mrs. Maryanna Rohr	ıbach in-l	aw) 3303	Willow	oet and Numbe Jhby Ro	or Or Rural Route Num ad, Baltin	ber, City or	Town, State, Zip		34
more,	Part and		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 🕱 Other (Specify)	Entombment	COD. Place of Dispo cometery, cres Gardens	of Fait	h Maus	3/2/2005	Balt	in ation - City or To	Marula	nd
4	permit. Departr Imports any Inj		21. Signature of Funeral Service License Button Ce U 23a. Part1. Enter the disease, or complie	eller		9705 Be	lair Rd	Schimunek ., Baltimo	re, M		Approximate	Φ.
	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.				FECTION			Onset and (
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co								
8760,	cate be executed physicien and s the burial-transit	dical Examiner	Cause (Disease or influty that initiated events resulting in death) Last	Due to (or as a co	insequence of):							
.O. Box 6	death certifi e attending id for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregna Other (specify			23	3d. Date of delive	-2	Year
S, D	sign sign	ed by Pr	Part II. Other significant conditions con	TIA	ot resulting in the u	nderlying cause	given in Part I.		tobacco us	e contribute to to		leath? Inknown
Vital Record	: The law requicate has been page 2 should	Completed	HYPE1	nTION				24a. Wa aut per 1 □ Yes	opsy formed?	death?	opsy findings ampletion of ca	available ause of
ivision of Vita	Attanding Physician: The la rr death. ector: Atler this certificate has by the funeral director, page 2	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o Injury	f 28c. li	24	of Death Check onlorsing Home 5 Res 28d. Describe	sidence 6		(y)	
oivis	oltal or Attandurs after deathurs after deathurs! Aral Director: Alled in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	Specify)			City or To	own, State)	Number or Rura		ber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 10 Certifying Physical Examination (Check only one) 12 Certifying Physical Examination (Check only one)	sician: To the best of mer: On the basis of exa	y knowledge, deat amination and/or in	h occurred at the vestigation, in m	y opinion, deat	d place, and due to the	e cause(s) a e, date and p 29d. Date	and manner as solace, and due to	tated. the cause(s)
ŧ	4		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type.	DO (0617	65	FEBU	RANY	28 20	202
	Sta	te	(Check only one) 29b. Signature and title of certifier 30. Name and address of person who co	1N00 33 32. Registrar's	SO WILL	LENS A	UE #	101 BACTI	mone	- no.	2122	9
	Registr	ar	MAR 0 3 20	305 Kilosin	w St. A	TOBACE!						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Joseph Michael Reuschling February 5:45 P M 28, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Eastpoint Nursing & Rehab. Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) MaryLand 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** 1 XM 2 ☐ F 217-14-2834 81 June. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other then "natural", or Itams 23a or 28a-f shov other traumatic event, the Medical Examination as the notified at 1 ☐ Yes 2 X No Baltimore. Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2400 Lincoln Ave., Lot # 28 21219 u.s.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Ital 1 MYes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Residential and I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Commercial Painting Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0'Dwyer Johanna William Reuschling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Agnes F. Reuschling (wife) 2400 Lincoln Ave., Lot#28, Balt., MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. *4 □ Donation 5 □ Other (Specify)

21. Signature of Juneral Services Acets Services 3/03/2005 Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 10 9705 Belair Rd., Baltimore, MD 21236 AN all 23a. Part. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart full ure. List only one cause on each line. Immediate Cause (Final Physician therosciesote Fleunt disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ver asclerosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760,< Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? þ Splast. Welle Syndronia 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Zheimes! 24a. Was an page 2 s autopsy performed? certificate 2 NO 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nersing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Injury 1 Alural 5 Pending death. 1 ☐ Yes 2 ☐ No thin 24 hours after death.

o the Funeral Director: A
ompletely filled in by the fi investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 94 29b. Signature and title of pertified 29c. License number 29d. Date signed (Month, Day, Year) 5 0 W 11156 30. N e and address of person who completed cause of death (Item 23a) (Type, Print)

ELITE M. JOMES MO 44 5: ELLWOOD AVE 120 MP 2/22 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 03 2005

		. For	State of Marylai				•	•	gible.	0.100 to 1
		1 - State Registrar		Ce	rtifica	te of Death		Reg. No.	05 0	7140
Phys	cian	Decedent's Name (First, Middle, La					2. Date of D	Day	Year	Time of Death
/Me	dical	James Roberts 4a. Facility Name (If not institution, giv			4h Cit	y, Town, or Location of De	ath ath		3005	M STE
Exan	ııner	University Spec	4 11		Ba			10.000	ity of Death	
Funera	al	5. Social Security Number 6. S		last birthday)		ler 1 Year If Under 24 H	n. (Month, D	av. Year)	9. Birthplace	(State or Foreign
Directo	or	215-30-4668 Usual Residence of Decedent	ZAW Z	70 Yrs.			10-14	-34	MD	
yland yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. i	nside City Limits
e Mar 3a-f s	ctor	MD	Ba	ltimo	re					Yes 2 □ No
with th	Funeral Director	10e. Street and Number				Zip Code			of What Country?	
leath y	erai	2500 W. Belvede	12. Was Decedent Ever in I	J.S. 13.		21215	(Specify Yes or N	USA 0- 14. B	ace - American II	ndian
after o	필		Armed Forces? 1 ☐Xes 2 ☐ No	- 1		pedent of Hispanic Origin? pecify Cuban, Mexican, Pure 22 No Specify:	erto Rican, etc.)		lack, White, etc.	
III. Z FZ 13-0030 be filed within 72 hours after death with the Maryland Hygiene. do ther than "natural", or items 23a or 28a-f show event, the Medical Evernment the colifical at	d b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:					Spec	ify:Black	
n 72 h	Completed	15. Decedent's E (Specify only highest gra		16a. Dece (Give	dent's Us kind of i	sual Occupation work done during most of w use retired)	orking	16b. Kind of	Business/Industr	у
d with giene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Chau				Self	Employ	ed
al Hyg	Be)			18. Mother's N	ame (First, Middle	, Maiden Sum	ame)	
Vica sould to Ment Ment Ment Ment Ment Ment Ment Ment	2	Harry Roberts					Cheeks			
d 2 sh th and th and 17 Is n traum	Ť	19a. Informant's Name/Relationship (Carroll Brown	Type, Print)			ss (Street and Number or anydays Colu				(e)
s 1 and 1 Heal		20a. Method of Disposition	20b.	Place of Dispo			Date Date		n - City or Town,	State
Page nent o		1 ☐ Burial 2 ☐ Xremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specil	Tuellinasi tintti State			ematory 3-	1-05	Dunda	lk, MD	
partition of the pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmoortant: If them 27 is americal other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at	eg l	21. Signature of Funeral Service Licer		22	2. Name	and Address of Facility We	esley C	havis	Jr. F	Н
0056	OI .	23a Part 1 Enter the disease or com	plications that caused the dos			Eastern A				proximate
Physicia		23a. Part1. Enter the disease or com shock, or heart failure List only Immediate Cause (Final						arrest,	Inte	erval Between set and Death
/Medica	ai i	disease or condition resulting in death)	a. Meta Due to (or as a conse		Ce	slay Cancer			3	many
Examine		Sequentially list conditions,	b							
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):						
be executed icien and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a conse	quence of):						
ys te	cal		d							
The law requires that the death certifica The law requires that the death certifica site has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:	220 If you outcome of proof							
eath c attend for us	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	al death 3	⊒Ectopic ⊒ Other (pregnancy specify)			Date of delivery Month Day	Year
the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
By Tha es tha gned I be det	by P	Part II. Other significant conditions			nderlying	cause given in Part I.			ntribute to the ca	
w requires been signs should be	Completed	prostate Conco	er Hypartonsia	7			. 10	Yes 2 No	3 Probably	4 □Unknown
2 8 8 0	mple					·	24a. Was		Were autopsy f prior to comple death?	tion of cause of
vital nec sician: The law s certificate has t lirector, page 2 s	ပိ	25. Was case referred to medical				25 Place of D	1 ☐ Yes eath (Check only	2 No	1 ☐ Yes 2 ☑	No
Physician: The this certificate hiral director, page	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 🗆 🛭	Other	Home 5 ☐ Res		ther (Specify)	
ing Phy ther this		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury at Work?	28d. Describe	how injury occu	urred	
Attending ar death. ctor: Afte by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b	e Oga Diago of Laive, At h	lomo farm et	M root fasts	1 Yes 2 No	28f Location	(Strot and Nun	nber or Rural Ro	uto Numbor
after after Direct din by	Certification:	4 Homicide determined	building, etc. (Speci	ify)	eet, lact	ory, ornos		wп, State)	nber of rigidi riol	zie ivanioer,
To the Hospital or Attending Physician: Within 24 hours after death, within 24 hours after death of the Funeral Director. After this certifics completely filled in by the funeral director,	edical C		nysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the time, date and pla on, in my opinion, death oc	ce, and due to the curred at the time	cause(s) and n date and place	nanner as stated e, and due to the	cause(s)
To the To the	Me	29b. Signature and title of certifier			2	9c. License number		29d. Date sign	ned (Month, Day,	Year)
						D30494		02/02	5105	
		30. Name and address of person who				sath chances	Char-1-	nalhma	- 4441	J 2
	State	31. Date filed (Month, Day, Year)	32 Aegistrar Sign		60	SOUTH CHENCES	3100/-1	39111110	CALDER	
Regi		MAR 0 3 2	005	K de	SAL	P				

	1	For State Registrar		State	of Maryla		rtmen <i>tificat</i>				-	giene Reg. No.	2111)5	0714
Physician /Medical		Decedent's Name	e (First, Middle, i Edward	Last)		Ri	ce				2. Date of De Month Februa	Day		rear 005	3. Time of Dear 20:50
Examiner	_	a. Facility Name (II	not institution, g	rive street and	number)		4b. City,	Town, or	Location of	of Death		-	County of		1_0.50
	L	Sinai Ho						timo		0.111			NA		
Funeral Director		Social Security No. 215–30–9	063	.Sex 1□M 2🖔		rs. last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 9-1-	th y, Year) -35		9. Birthp Cour	place (State or For htry) Md.
A =	\vdash	sual Residence of Da. State	10b. County		10c. 0	City, Town or Lo	cation							1	0d. Inside City Lir
tor tor		Md.	N	A		Bal	timor	e							1 XYes 2 □
3a or 28e il De nol	1	0e. Street and Nun	nber Coldsp	ring La	ane		10f. Zip		215				izen of Wh	at Cour	ntry?
penint. Tages I and 2. Strong data the winter a fronts are dean with the waryand Department of Health and Mental Hygiene. Industrial, or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1	1. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		Armed 1X7Y	Decedent Ever in 1 Forces? es 2 No Give or Dates:	1	Vas Deced Yes, spec				cify Yes or No Rican, etc.)	-	14. Race Black,	White,	etc.
ygiane. nar than "natura it, the Medical E		(Speci	15. Decedent's ify only highest only highest only highest only (0-12)	grade complet	e <i>d)</i> ge (1-4or 5+)		kind of wor OO NOT us	rk done d se retired,	luring mos)	t of workir	ng		ind of Busi		
ygien har th it, the		12th gra				Mil	l Ope	rato					ional		psum
Mental H arkad oth artic evan		7. Father's Name (Edward		W.	R	ice, Sr				Inez	(First, Middle,		Rec	ld	
11th and 27 is my		9a. Informant's Na			Wife						ne, Ba				Code) 21215
or other	2	Da. Method of Disp	osition Cremation 3	☐Removal fr	20b om State	. Place of Dispo cemetery, cren	sition (Nan	ne of ther place	9)	D	ate	20c. Lo	ocation - C	ity or To	
rtmen rtant: njury		MG Burial 2 □ Cremation 3 □ Removal from State `4 □ Donation 5 □ Other (Specify) Md. Vet. Cem. 3-4-05 Crownsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202													
Depa Impo any ir		> A J	laky	W	como		March						re, M North		21202 e.
physician and in the burial-transit and cale Examiner	ti c	sequential, list cor any, leading to im ause. Enter Unde lause (Disease or nat initiated events asulting in death) L	mediate rlying injury	b. Due	to (or as a conse	equence orj:									
r death. actor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as th iffication: To Be Completed by Physician/Medi	11 2	FFEMALE: 3b. Was decedent in the past 12 1 Yes 2 5	months?	1 □ Li 4 □ Pr	outcome of preg ve birth 2 Te regnant at time of nknown	etal death 3	Ectopic pro					2	23d. Date (Month		ry Day Year
signed to	, P	art II. Other signifi	icant conditions	contributing t	o death but not re	esulting in the ur	iderlying ca	ause give	n in Part I.			obacco u /es 2[ute to th	e cause of death
h. After this certificate has been si funeral director, page 2 should for the transfer to the Completed		5. Was case refer									1 Yes	sy rmed? 2 □ No	prid	or to con oth?	osy findings availa npletion of cause 2 \(\text{No} \)
his certi		examiner?		Hospital: 1	☐ Inpatient 2	☑ER/Outpatien	3□ DO	A Othe			_(Check only only only only only only only only		3 DOther	(Specific	,)
ctor: After this the funeral di		7. Manner of Death 1 Natural 2 Accident		28a. Da	ate of Injury Month, Day Year)	23.		Bc. Injury Work	at ? 'es 2 🗆 1	2	8d. Describe h				7
a in in		3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	280. PI	ace of Injury - At uilding, etc. (Spec	home, farm, stri cify)	et, factory	, office		2	8f. Location (5 City or Tox	itreet and m, State	d Number)	or Rura	Route Number,
in 24 hours a the Funaral I pletely filled	2	9a. Certifier (Check only one)	1 ☐ Certifying 2 XMedical Ex	aminer: On th	the best of my kine basis of examinancer stated.	nowledge, death nation and/or inv	occurred a estigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	nd due to the	cause(s) date and	and mann place, and	er as sta d due to	ated. the cause(s)
within 2 To the complet		9b. Signature and	title of certifier				1	License	number			29d. Date	e signed (i	Month, L	Day, Year)
		> fan	atiso	rethall.	mo			OCME				Fel	bruar	y 28	3, 2005
127	3	0. Name and address Pamela		hous, M		ет 23а) (Туре,	Print)	l Pei	nn St	reet	Baltin		10.00		nd 21201
State Registrar	3	1. Date filed (Mont		2005	2. Pe gistrar's Sig			,							

		Please T	ype or Print in Black					
		1 _ For State	State of Maryland / De			ental Hygie	ne no E	07110
		Registrar 1. Decedent's Name (First, Middle, Last)	(Certificate of	Death	Reg.	No UUJ	0/142
Physici		TOMES FOL	DON DING	74.1	-		Day Year	3. Time of Death
/Medio Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town,	or Location of Death	EBRLARY	4c. County of Dea	
Examin		GILCHRIST	CENTER	TOU	(50L)		BALTI	MORE
Funeral		5. Social Security Number 6. Sex	M 2 F	Months Davs		8. Date of Birth (Month, Day, Ye	ar) 9. Birt	hplace (State or Foreign
Director		Usual Residence of Decedent	(M 2 L) F (G 3 Y)	S.		3127/19	4) M	TINE
yland		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
e Mar	ctor	MD HOWF	TRD COU	MBIA				1 ☐ Yes 22 No
death with the Maryland ms 23a or 28a-f show rmust be nutified at	Funeral Director	10e. Street and Number	514-1111	10f. Zip Code	21.1.1	10g.	Citizen of What Co	ountry?
eath v	eral	5954 TURNAB	2. Was Decedent Ever in U.S.	3 210	<u> </u>	U	NITED	STATES
riter d	Fun	1 Never Married 2 Married	Armed Forces? 1 XYes 2 No If Yes, Give		Hispanic Origin? (Spec ban, Mexican, Puerto F	tican, etc.)	14. Race - Ame Black, Whit	
be filed within 72 hours after tal Hyglene. d other then "natural", or ite event, the Madical Examins	by	3 ☐ Widowed 4 Divorced	If Yes, Give Year or Dates: UNKNOW	1 □ Yes 2 No	Specify:		Specify: W	HITE
"natu	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a. D completed) (0	ecedent's Usual Occu Give kind of work done	during most of working	g 16b	. Kind of Business/	Industry
withir ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	ife. DO NOT use retire	19T	m	ACHIN	SHOD
illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)	/ / /	HOMIN	18. Mother's Name			SHUP
utd be Menta urked	To B	JAMES WESL	EY RIDLON		VIVIAN	10018	E THE	RSTON
2 shoutd and Mer is marke	·	19a. Informant's Name/Relationship (Typ		Mailing Address (Stree	t and Number or Rural	Route Number, Cit	y or Town, State, 2	Zip Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural; or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.		ANNIE PLUMME 20a. Method of Disposition	ER/FRIEND 595	TURNAL Disposition (Name of	30UT LN F		JOLUMBI	
Pages nent of I int: if ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		crematory or other pla	ace)	12 (19)	Location - City or	
nit. Partme		 4 Donation 5 ☐ Other (Specify) 21. Signature of Funday Service License 	ANAIU	22. Name and Addre	KG HJ3	105 H	HNOVEK	,mus
permit. Depart Import eny inj		M-H Wate			Daugherty Family			
		23a. Pa 11. Enter the disease, of implication shock, or heart failure. Lift only	cating that can ed the death. Do not	t enter the mode of dyi	ing, such as cardiac or	ain Road - Pas respiratory arrest,	acena, MD. 211	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Metastatic	Hepatoc	ellulon		noma	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of)					
1 7 3	Ē	Sequentially list conditions, if any, leading to immediate	Lu6 to (or as a consequence of)					
uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	, , , , , , , , , , , , , , , , , , , ,					
		resulting in death) Last	Due to (or as a consequence of)					
	Physician/Medical	d						
ieeth certificate b attending physic i for use as the b	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy					
atten 1 for u	cian	in the past 12 months?	1 Live birth 2 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у		23d. Date of deli Month	very Day Year
t the d by the achec	hysi	1 Yes 2 No 9 Unknown	9□ Unknown					
res that the de signed by the a be detached f	by P	Part II. Other significant conditions conf	tributing to death but not resulting in th	ne underlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
w require been sli	ted					1 🗆 Yes	2 100 3 □ Pro	obably 4 □Unknown
has be	Completed					24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
sician: The law certificete has t irector, page 2 s						performed		2 🗆 No
siciar s certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Oth	26. Place of Death		25771	Hospice
g Phy er this ieral d	n: To	27. Manner of Death	28a. Date of Injury 28b. Tim	ne of 28c, Inju	her: 4 ☐ Nursing Hom ry at 28	d. Describe how in	jury occurred	ity) it copied
endin sath. or: Aft	atio	1 Accident 5 Pending investigation	(Month, Day Year) Inju		Yes 2 □No			
or Att fter de Nrect	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28	f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
spitai ours a ierai E		29a. Certifier 1 Certifying Physi	ician: To the best of my knowledge, d	ingth coourad at the ti	ma data and slace as		(-)	
To the Hospital or Attending Physician: The law requires that the deeth certificate within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2 Medical Examin	er: On the basis of examination and/o and manner stated.	or investigation, in my o	me, date and place, ar opinion, death occurred	d due to the cause I at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	1 17	29c. Licens			Date signed (Month	
		A Bonth	my felly, "	0 02	25205	te	brunny:	25,2005
		30. Name and address of person who con	npleted cause of death (Tem 23a) (Ty	pe, Print)	St. Belt	m/ >	1201	
Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Signature	. Copies	J. Decr	7710 2		
Sta Registra		MAR 0 3 201		1.0				

DHMH 17 Rev 1/2001

ORIGINAL

05-1557 B.K.S SYED RIZVI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1	(12v1		1 - For State Registrar	State	of Maryla		artment of F		Mental Hygie	ene 0 0 5	07143
ı	Physici	an	1. Decedent's Name (First, Middle,						2. Date of Death		3. Time of Death
	/Medic	al	SYED B. ALI 4a. Facility Name (If not institution, (RIZVI	ımber)		4h City Town o	r Location of Deat	MARCH	1, 2005 Year 4c. County of Deatt	1525 P M
	Examin	er	UNIVERSITY HO				BALT	r Location of Deat EMORE CIT	ΪΥ	4c. County of Death	1
	Funeral Director		5. Social Security Number 6 214-69-8925	.Sex 1 X M 2□ F	7. Age (In yr. 55	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		ear) Coi	nplace (State or Foreign untry) KISTAN
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	cation				10d. Inside City Limits
	a-f sho	tor	MD MONTGO	MERY	В	URTONSV	TIIF				1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number 3909 COTTON TREE				10f. Zip Code			Citizen of What Co	•
	death with the Maryland ms 23a or 28a-f show rinust be nytffled at	Funeral Director	11. Marital Status		cedent Ever in	U.S. 13.	20866 Was Decedent of H	lispanic Origin? (S		AL RESIDE	
2-00-0	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than "natural", or items 23a or 28a-1 show event. I'te Madical Examination at the natified at	þ	1 Never Married XXMarried 3 Widowed 4 Divorced	Armed F	orces? 2 No ive		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	to Rican, etc.)	Black, White	i, etc. I AN
2	n 72 h natu	Completed	15. Decedent's (Specify only highest	Education grade completed,)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of wo	rking 16	6b. Kind of Business/I	
7 7	filed within Hygiene. ther than out. The Wei	ошо	Elementary/Secondary (0-12)	College ((1-4or 5+)	CASHI		1)	(GAS STATIO	N
aud	be filed ital Hyg id othe event.	Be	17. Father's Name (First, Middle, La	st)		0.10112			me (First, Middle, Ma		
Z	d 2 should be th and Mental 7 Is marked of traumatic ev	2	SYED ZULFIGAR AL						ISA BEGUM		
Z	コピトラ		19a. Informant's Name/Relationship SYED ALI/BROTHER							City or Town, State, Z TLLE, MD	
nore,	Pages 1 and ent of Healt it; if item 2 y or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe		State	Place of Dispo	sition (Name of natory or other place	ce)	Date 20	Oc. Location - City or T	
Dailimo	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service Lie		<u> </u>	2:	2. Name and Addre	ss of Facility 🗜 [LECK FUNER	RAL HOME, I REL, MARY	INC.
	Physician		23a Part1. Enter le disease, or co shock, or hear failure. List or Immedia: Final disease or condition resulting in death)	ly one cause on	each line.	ath. Do not ent		g, such as cardiad			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in deality	Due to	(or as a conse	equence of):					
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conse	equence of):					
	and I-trans	Examiner	cause. Enter Underlying Cause (Liecase of injury) that initiated events resulting in death) Last	c	(or as a conse	acuence of)-					
9/00/	icate be executed physician and s the burial-transit	dicai E		d	(01 45 4 551136	5440/100 (1).					
0	rtificat ng phy as th	03	IF FEMALE:								
C. BOX	he death certificate be executed the attending physician and ched for use as the burial-transif	Physician/Mo	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	itcome of preg birth 2 □Fe nant at time of nown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of delin Month	very Day Year
ds, r.	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions	s contributing to o	death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
spiosa	w req beer shou	ompleted							24a. Was an		opsy findings available
ř	The ate h	Com							autopsy performe 112 Yes 2	id? death?	ompletion of cause of 2 No
N I I	ysician: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:	7	7	Oth		ath (Check only one)		
<u></u>	ding Phys h. After this funeral dir); To	1X Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time o		4 Nursing H	lome 5 ☐ Residen	ce 6 Other (Speciniury occurred	ify)
001	ath. rr: Afte	atlor	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat	(Moi	nth, Day Year)	13:51		k? Yes 2 □ No	Subject	shot	
UNISION	or Atta	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	288. Plac	e of Injury - At ting, etc. (Spec	cifu) .	eet, factory, office	4 1.	City or Town,		_
_	ours a	al Ce	29a. Certifier 1 ☐ Certifying	Physician: To th	a hast of my ki	-	Gas sta			2d. Silver See(s) and manner as	1
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certifica completely filled in by the funeral director,	ledicai	(Check only 200 Medical Ex	aminer: On the b	pasis of examination of stated.	nation and/or in	vestigation, in my o	pinion, death occu	irred at the time, date	e and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		re	,	29c. Licens			I. Date signed (Month	
	1		20 Name and address of access	Wer	T 7	om 22=1 /T		ME	1	,	2005
}	1,		30. Name and address of person when I H C					nn Stree	t Baltim	ore, Maryl	and 21201
	Sta Registr		31. Date filed (Month, Day, Year)	2005	Registrar's Sign	nature	selv.				

	_		1 - For State Registrar			Depa		lealth and N Death	lental Hyg		0 5	07144
в	Obvoio		1. Decedent's Name (First, Middle, L	ast)					2. Date of Dea	ıth		3. Time of Death
	Physic /Medi		Kenneth		Ransdel	.1			Feb 28,	2005	Year	3:40 A.M
	Exami		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	r Location of Death			ty of Death	
			Villa Rosa Nurs	sing Home			Mitchell	ville		Prin	ce Ge	orge's
	Funeral				e (In yrs. last bir	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		place (State or Foreign intry)
	Director		400 54 9647 Usual Residence of Decedent	XXM 2□F	66	Yrs.	Months Days	Hours Min.	Feb 8,	1939		tucky
	ylanı		10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	Ma s	ţċ	Maryland Prince	George		C	Linton					1 ☐ Yes 2 ☐ No
	r 28	Director	10e. Street and Number				10f. Zip Code		1	l 0g. Citizen o	f What Cou	
	n 72 hours after death with the Maryland "natural", or Items 23c or 28a-f show valical Exercires must be notified at	a D	9402 Pir	eview Lane			2	0735			ed Sta	
	dea dea	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of H	ispanic Origin? (Spi in, Mexican, Puerto	ecify Yes or No-		ace - Ameri	
ဖွ	after or Ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces?	Vietnam	1			Rican, etc.)	BI	ack, White,	, etc.
8	ral',	l by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	vietham	1	Yes AX No	Specify:		Spec	^{ify:} Whit	te
5-0	72 h natu	etec	15. Decedent's ((Specify only highest g	ducation	16a.	Deced	lent's Usual Occupa	ation		16b. Kind of I		
2	d within giene. or then "	ldu	Elementary/Secondary (0-12)	College (1-4or 5	5+)	inte. L	OO NOT use retired	,				
7	77 To be 100	Completed	12		l	1sgt	Retired	Police S				
pu	d d o	Be	17. Father's Name (First, Middle, Las	Maiden Suma	me)							
<u>ya</u>	should be and Mental marked o	10	Curtis Ransdell					Edith	Allen			
Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 2008.		19a. Informant's Name/Relationship Jacqueline Pugh	(Type, Print) (Executor) 19b.	. Mailin 9402	g Address (Street a	and Number or Rura W Lane, C	Al Route Number	City or Town	s, State, Zip	7 Code)
Baltimore,	of Hea		20a. Method of Disposition					March 3		20c. Location		
Ĕ	permit. Pages Department of I Important: If its any injury or o		1	⊔Hemoval from State fy)	Mary1	and	Veterans	Cemeter	y 2003	Chelt	enhan	n, Maryland
alt	permit. Departr Importa any inju		21. Signature of Funeral Service Lice			22.	Name and Addres	s of Facility Lee	Funeral			
<u> </u>	80 5 5 8		Brown	M0142	2	A1	exandira	Ferry Roa	ad. Clin	iton. M	larv1s	nd 20735
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	polications that caused	the death. Do n	ot ente	er the mode of dying	g, such as cardiac o	r respiratory arre	est,	12 9 20	Approximate
	Physician		Immediate Cause (Final disease or condition	Δ	CALL	1.	. AL	044				Interval Between Onset and Death
	/Medical		resulting in death)	Due to for as	a consequence of	of):	(144	60 marca				Weeks
	Examiner		Conventingly that are distance	. De	x: X-15		M- Ku	a. h.				9
	n	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	of):/	0	11	0=		-	123
	icate be executed physician and s the burial-transit	Examiner	that initiated events	C								
O	an a lan a	EX	resulting in death) Last	Due to (or as	a consequence o	of):						
8760,	ate b hysic he bi	Physician/Medical	•	d								
9	death certifica attending pt of for use as the	Med	IF FEMALE:									
Вох	tendi r use	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy	3 □	Ectopic pregnancy			23d. Da	ate of delive	ery
о <u>.</u>	the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown			Other (specify)			Mo	onth	Day Year
<u>Ч</u>	ac ac	Phy	9 Unknown									
Ś	uires tha signed I d be det	by	Part II. Other significant conditions	contributing to death bu	it not resulting in	the un	derlying cause give	n in Part I.	23e. Did tob	acco use con	inbute to th	e cause of death?
Record	w requir been si should	Completed							1 ☐ Ye	s 2 No	3 Prob	ably 4 Johknown
ec.	e lawr has be je 2 sh	ple							24a. Was an		Were autor	psy findings available
<u> </u>	The ate has page	OL							autopsy	led?	death?	npletion of cause of
Vital	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical					26. Place of Death			1 🗆 Yes	2LI NO
>	Physicien: r this certifica ral director, p	10	examiner? 1 \(\text{Yes} \) \(\text{2nNo} \)	Hospital: 1 Inpatier	nt 2 ER/Out	patient	0.1				or (Specifi	
0	ding Pl h. After th funeral		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	(Year) 28b. Ti	me of	28c. Injury Work		8d. Describe how			/
0	ottendia death. ctor: Al / the fu	atlo	2 ☐ Accident investigatio	n	1007	jury		es 2 No				
Division of	or Atten after deatl Director: in by the	Certification:	3 Suicide 6 Could not b		ry - At home, fam	m, stree	et, factory, office	2	8f. Location (Str.	eet and Numb	er or Rura	Route Number,
	lospital or A tours after uneral Director bild bild bild bild in by bild bild bild bild bild bild bild bild								City or Town,	,		
		edical	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	ysician: To the best on niner: On the basis of and manner state	Branninanon and	death (/or inve	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre	nd due to the car d at the time, da	use(s) and ma te and place,	inner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of pertifier	/			29c. License	number	29	d. Date signe	d (Month 1	Day, Year)
			P\()	11 kus	m		1	2261		_		
,	1	-	30. Name and address of person who	completed cause of do	ath (Item 22a) /7	Type D	1 11	0001		16- 6	-6 - 6	_005
F	11		Rilly TE.D.	~~ M	9 NV	Α.	tinti This pake	5 008	1 A.	L.	20	20706
9	Sta	te	31. Date filed (Month, Day, Year)	32. Resistra		/ 1	/	, , ,	C - , , p			C. / U
	Registr		MAR 03	2005 1600	w. H.	1	rails					

			For State Registrar	State of Ma	arylan	-		t of H		ind Me	ental Hygi	g. No.	005	07145
п	Physici	an	Decedent's Name (First, Middle, Last) ET CA MAD TE	T) ETTATZ							Date of Death Month	Day	Year	3. Time of Death
	/Medic Examir	cal	ELSA MARIE 4a. Facility Name (If not institution, give s Saint Joseph Me	REHAK treet and number) dical C	ent 6	3 h.	4b. City,	Town, or	Location o		FEBRUARY		2005 ounty of Death	
	Funeral Director		5. Social Security Number 6. Sex 218-09-5333	7. Age	86	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, May 8,1	Year) 918	Coul	place (State or Foreign ntry) / Land
	// show	ō	10a. State 10b. County Maryland Baltimore			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the Page or 28a-	Direct	10e. Street and Number 95 Dunkirk Road			i Cino	10f. Zip	Code 212			10	-	en of What Coul	
36	be filed within 72 hours after deeth with the Maryland ital Hygiene. id other than "naturel", or itame 23a or 28a-f show event, Its Modical Exaciles could be notified at	by Funeral Director		12. Was Decedent & Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		'	Was Deced	dent of Hi city Cuba	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	city Yes or No- lican, etc.)	14	Race - Americ Black, White,	
Maryland 21215-0036	in 72 hou n "nature decical E	Completed I	15. Decedent's Educ (Specify only highest grade	cation completed)		16a. Deced (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired,	ition luring most)	of working	g 1	6b. Kind	d of Business/In	
212	filed with Hygiene. Ither than	Com	Elementary/Secondary (0-12)	College (1-4or 5	+)	C:	lerk						Railroa	d
yland	should be filed within and Mental Hygiene. I marked other than umatic event, It a M	To Be	17. Father's Name (First, Middle, Last) Joseph		Reha	ak				rs Name Marie	(First, Middle, M	laiden St		boda
Mar	2 a a a		19a. Informant's Name/Relationship (Typ. V. Bruce Hirshauer	_{ов, Print)} Fri	end	1	-				Route Number, Maryland 2		Town, State, Zip	Code)
	Peges 1 and 3 nent of Health int: if item 27 iry or other tr		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Re		20b. P	Place of Dispo cemetery, cren	sition (Nam natory or o	ne of ther place	9)	Da	ite 2	Oc. Loca	ation - City or To	
Baitimore,	permit. Peges Depertment of Important: if it any Injury or o		2 Ignature of Funeral Service License	a Hou	n b	owridge 22			s of Facility	11200	chell-Wied	efelo		and Home Inc and 21212
	Priysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused e cause on each lin	IA a conseq	uence of):	er the mod	le of dying					, raiyi	Approximate Interval Between Onset and Death
8760, <	ate be executed sysicien and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		LEM:	uence of):								
P.O. Box 68	The law requires that the deeth certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burtal-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 □Feta	I death 3	Ectopic pr Other (sp					230	d. Date of delive	ery Day Year
	uires that i signed by id be deta	by	Part II. Other significant conditions con	tributing to death bu	ut not resi	ulting in the u	nderlying c	ause give	n in Part I.					ne cause of death?
I Records,		Completed									24a. Was an autopsy perform		24b. Were auto prior to cor death? 1 \(\text{Yes}	psy findings available mpletion of cause of 2 M No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				Otho			Check only one			
of	ing Phys n. After this funeral di	tion: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 X Inpatie 28a. Date of Injur (Month, Day		28b. Time of Injury		8c. Injury Work	at ? ′es 2 □ N	28	e 5 Resider			γ)
Division	ol or Attendi effer death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	iry - At ho	ome, farm, str	eet, factory	r, office		28	Bf. Location (Stre City or Town,		Number or Rura	I Route Number,
	To the Hospitel or Attending within 24 hours effer death. To the Funeral Director: Affe completely filled in by the fune	Medical C	29a. Certifier 1X Certifying Phys (Check only one) 2 Medicel Exemin	sicien: To the best of er: On the basis of and manner sta	examina	owledge, death tion and/or inv	occurred vestigation,	at the tim in my op	e, date and inion, deatl	d place, and	nd due to the cau d at the time, dat	use(s) an	nd manner as st lace, and due to	tated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	melto	m	0.10		: License				d. Date s	signed (Month,	Day, Year)
,	C		30. Name and address of person who co	mpleted cause of de	eath (Item	1 23a) (Type,	Print)	414	+ 1 1/2		1	-NT(ichy 27	1400
	Å,		JOGINDER F' MEH	TA. M.D.	. 7	601 0		DR	IVE,	TOW	50N, M	ARYL	AND 2	1204
	Sta Regísti		MAR 0 3 200	5 Asac	, s signa	ture								

			1 - For State Registrar		aryland / D	c Indelible Ink repartment of F <i>Certificate of</i>	Health and Me	ental Hygi	_	07146
	Physici		1. Decedent's Name (First, Middle, La Nancy E. Ritchie	•				2. Date of Death		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of Death	1 www	4c. County of Deat	
			Doctor's Communi 5. Social Security Number 6. S	ty Hospita	al ge (In yrs. last birti	Lanham	If Under 24 Hrs.	8. Date of Birth	Prince	George
	Funeral Director			_M 2 XF /. A9		rs. Months Days	Hours Min.	an. 7,	1918 Wes	thplace (State or Foreign buntry) St Virginia
	and and the stand		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. fnside City Limits
	death with the Maryland ims 23s or 28s-f show	Director	MD Prince	George	Lanham					1 ☐ Yes 2/G√No
	with to	Dir	10e. Street and Number 5411 Arnold Drive			10f. Zip Code	706	10	og. Citizen of What Co	untry?
3	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H		cify Yes or No-	USA 14. Race - Ame	
lant 5-0036	filed within 72 hours after death with the Marylan Hygiene. Hygiene, the Weathan "natural", or Itams 23a or 28a-f shownt, the Medical Exanana must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1 ☐ Yes 2X No		ncari, etc.)	Bfack, White	
	in 72 ho "natur edical	olete	15. Decedent's E. (Specify only highest gra	ide completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of working d)	g 1	16b, Kind of Business/	Industry
7	d with glene. er than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Homemake			Own Home	
RITCHIE	d 2 should be filed withln th and Mental Hygiene. 7 Is marked other than "traumatic event, the Men	Be	17. Father's Name (First, Middle, Last,	Thompson			18. Mother's Name		faiden Sumame)	
TCH18	should od Mer marke matic	ဥ	19a. Informant's Name/Relationship (19b.	Mailing Address (Street	Emma Co.		City or Town State 2	Zin Code)
F 2	- 6567		Crystal McHenka			ll Arnold E			20706	
& 5	Pages 1 and nent of Healt int: If Itam 2 iry or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of	Disposition (Name of crematory or other pla	Da		20c. Location - City or	Town, State
Raltimore	permit. Pages Department of Important: If If any injury or o		 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service bicer 	y)	Meadow	ridge Mem. 1		2005	Elkridge,	MD
ď	permi Depa Impo any ir		MSK. Ho	idema	\sim	Gary L. Ka 7250 Washi	ufman Fune	ral Home	e@Meadowr	idge MP, Inc.
•	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Saguin tlany list our altions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due fo (or as	ine. LU MU a consequence of a consequence o	hronic			Insuffic	Approximate Interval Between Onset and Death
8760	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cOue to (or as	a consequence of	7	y dise	en		
D O Rox 687	t the de by the	Physician/Medi	fFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetaf death	3 □Ectopic pregnanc 5 □ Other (specify) □	у		23d. Date of defi Month	ivery Day Year
- E	signed d be del	by	Part II. Other significant conditions of				ven in Part I.		acco use contribute to s 2 □ No 3 □ Pro	the cause of death?
Š	aw requires been si	ompleted	Atra	Insuf.	hurl	a Fin		24a. Was an		itopsy findings available
ä	The law cate has page 2	Com		(autopsy perform	ed? death?	completion of cause of 2 No
; ;	ysician: The	Be	25. Was case referred to medical examiner?	Hospital:		0#	26. Place of Death		-	
Ť	g Phys ar this eral dir	n: To	1 Tyes 2 No 27. Manner of Death	28a. Date of Inju (Month, Da		ime of 28c. Injur	4 LI Nursing Hom		nce 6 Other (Spec	ify)
	ending Fath.	atlo	1 Natural 5 Pending investigatio	1	ay Year) In		rk? Yes 2 □ No			
Division of Vital Becords	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f.	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of Inj	ju ry - At home, far tc. <i>(Specify)</i>	m, street, factory, office	28	3f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral E completely filled	edical	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example	niner: On the best niner: On the basis o and manner st	of examination and	death occurred at the tir Vor investigation, in my c	me, date and place, ar opinion, death occurred	nd due to the cau d at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	2 7		29c. Licens	se number	29	d. Date signed (Month	ı, Day, Year)
	n		the	m K	2	2	22/1/		Marci	41,2005
	7		30. Name and addr f person who	co eted cause of c	death (Item 23a) (T	Type, Print)	SCITE 107	LANA	AM, MS ?	61,2008 20706
	Sta Regist		31. Date filed (Month, Day, Year) MAR 03	2005 32. Ragistr	rar's Signature	Aprile		- / 1//		

		riedse	State of Maryla				•		egible.	
		1 - For State Registrar	Otate of maryia		tificate of L			Reg. No.	2005	07167
		Decedent's Name (First, Middle, Last,)				2. Date of Dea	ıth		3. Time of Death
Physic		Katherine		5m	th		March	Day Z	Year 2005	437 AM
/Medi Exami		4a. Facility Name (If not institution, give	street and number)	,		Location of Death	1 1	4c. C	County of Deat	
		THE Johns He	spkins Ho	Spital	BAH	more C	SH			
Funeral		5. Social Security Number 6. Sec	7. Age (In yr	(last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Month, Day	(, Year)	C 60	holace (State or Foreign
Director		Usual Residence of Decedent					JOCT	د ۱۹ ره	\	J.S.A.
how	_	10a. State 10b. County	10c. 0	City, Town or Loc						10d. Inside City Limits 1 ✓ Yes 2 ☐ No
Ba-f o	by Funeral Director	mo.		BHLI	IMORE	•				
with ti	Dir	10e. Street and Number	+ nus		10f. Zip Code	1 =		10g. Citiz	en of What Co	ountry?
eath	era	11. Marital Status	ST AVE 12. Was Decedent Ever in	U.S. 13 V	Vas Decedent of H	ispanic Origin? (Si	pacify Yas or No-	1	4. Race - Ame	nican Indian
fter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Vas Decedent of Hi Yes, specify Cuba		o Rican, etc.)		Black, Whit	e, etc.
ified within 72 hours after death with the Maryland Hygiene. Hygiene. Inter than "natural", or Iteme 23a or 28a-1 show ant, if a Medical Exam retribute to hollified it.	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	Yes 2 No	Specify:		3	Specify: }	LACK
72 hc	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16a. Deced	ent's Usual Occupa kind of work done of OO NOT use retired	ation during most of wor	king	16b. Kin	d of Business	Industry
Aithin ne.	mpje	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT use retired))		α	JEDIC	nı
lied v dygie her t		17. Father's Name (First, Middle, Last)	<u>a</u>	1	JOKSC	19 Mother's Nan	ne (First, Middle,			
ntal he d ol	Be	Tark Cre	miler			RET	TVI	100	1ASO	
T Y Thould Me Me Merk	2	19a. Informant's Name/Relationship (7)	voe Print)	19b. Mailin	g Address (Street a	and Number or Ru	ra I Boute Numbe			
Md 2 s lith ar 27 ie r trau	1	STEPHANIE S	Time	1315	1 LARC	3/Appl	10	rEl	Mc	20708
S 1 at	1.3	20a. Method of Disposition		Place of Dispos	sition (Name of natory or other place	1	Date		cation - City or	
DESILITIOFE, MICE YIGHT A LATE 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any nigrry or other traumatic event, tra Medical Examinations to profite any organized to a profit of the pr		1 12 Burial 2 □ Cremation 3 □ F 1 4 □ Donation 5 □ Other (Specify)		Indo I	TEM. Pla		5,2005	W	1/600	NUF
Denti. Depart Imports any righ		21. Signature of Funary Service Linens	100	22	Name and Address	ss of Facility A	OWELL	FUR	SERAL	. Homis
40589		Carly	VIDA		600 LIBET	Ty HoT:	3vA c			
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the de ne cause on each line.	ath. Do not ente	ar the mode of dyin	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ucranial	Hemorr	hage				2 days
Examiner			Due to (or as a cons	1 . 1	m land	7				5 N/00
	e F	Sequentially list conditions if any, leading to immediate	Due to (or as a cons	equence of):	Edemo					> Clary=
d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Cer	10-09	arter	- rct				3 days
te be executed ysicien and le burial-transit		resulting in death) Last	Due to (or as a cons			\ \				
or ou	lical		a. Atherosch	to 21.201	cerepr	al arter	ies			>5 y +913
X 00 ertificat ding phy se as th	/Med	IF FEMALE:	23c. If yes, outcome of pred	2000						
DOX sath cer attendir for use	ian	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time of	tal death 3 [Ectopic pregnancy Other (specify)			23	3d. Date of del Month	ivery Day Year
The COTICS, P.O. BOX 08/ The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	hyslcian/Medi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknown	30	Otter (specify)					
that hed b	by Pt	Part II. Other significant conditions co	intributing to death but not r	esulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco us	se contribute to	the cause of death?
VII.di HECOIGS, iclan: The law requires! centificate has been signs rector, page 2 should be		hypertension					1 🗆 Y	′es 2 🗆]No 3∏Pr	robably 4 Unknown
aw re	ompleted	diahetes					24a. Was		24b. Were at	itopsy findings available
VICAL MEC reician: The law s certificate has b lirector, page 2 s	Eo	coronary artery	disease				autop perfor		death?	completion of cause of
Of VITA Physician: this certifical ral director,	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ith (Check only o	ne)		
OT V Physic this or	2	1 ☐ Yes 2 No		☐ ER/Outpatien		4 Nursing H	lome 5 Resid			cify)
on or ding Phys h. After this funeral di	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	k?	28d. Describe h	iow injury	occurred	
USIC tlend death death stor: ,	cat	2 Accident investigation 3 Suicide 6 Could not be		home form str		Yes 2□No	296 Logation /6	Stroot and	(Alumbar or C	ural Route Number.
DIVISION to or Attending after death. I Director: Afte	Certification:	4 Homicide determined	building, etc. (Spe	cify)	et, ractory, office		City or Tow		I Number of A	drai Houle Number.
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Certifying Phy	ysician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	, and due to the orred at the time, o	cause(s) a date and p	and manner as place, and due	s stated. to the cause(s)
ro the vithin o the comple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)
- 3 - 3		M.D	NCO RY	sident	RE	5-000		Mar	ch 2	2005
1)		30. Name and address of person who o	completed cause of death (II	em 23a) (Type,	Print)					
-		Michelle Petrovic			Nolfe st	reet, Bo	Himore	WI	2129	37
S Regis	tate trar	MAR 03 20	32. Filigistrar's Sig	K A	rede					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 28, 2005 **Physician** Charles Schafer /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign County) Maryland **Funeral** 1**⊠**M 2□F Director 212-07-0914 93 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits rei', or itams 23a or 28a-f show Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 → No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Walkern Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) Printer 8 Graphic Arts markad other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mental H Be John H. Schafer Pages 1 and 2 should nent of Health and Men ဂ Frances Schreiber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Robert Schafer (Son) 734 Town Center Drive, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 Purial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐Donation 5 ☐ Other (Specify) Gardens Of Faith March 3,2005 Baltimore, Maryland 22. Name and Address of actionski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on unch line. Immediate Cause (Final Enysician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. It yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23s. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩6 1 I patient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospitei or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

Manue

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause

#433584

Schater,

ot death (Item 23a) (Type Print)

32. Registrar's Signature

S. T. SALL

211

29c. License number

29d. Date signed (Month, Day, Year)

		1- For State of Maryland / I	Depa <i>Cei</i>	artment of H tificate of L	ealth a			Reg. No.	005	07149
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Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit XX 73	rthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da MAR 1	th y, Year) 3, 19 3	9. Birth Cou WI	place (State or Foreign ntry) EST VA
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ath w	ral	627 BRUCE ST		212				US		
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Manyland be filed within 72 hours after death with the Manyland d other than "natural", or flams 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★★Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ★★ S 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☐ No XX	spanic Ori n, Mexicar Specify:	gin? (Spec n, Puerto P	cify Yes or No Rican, etc.)		Race - Ameri Black, White, ecify:	
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G Z I Z I D- filed within 72 Hygiene. other than "nai	mp	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired				ann		
C Z I		12 S	ELF	EMPLOYEI		er's Name	(First, Middle	SERV Maiden Sui		
	To Be	LEONARD B. SMITH			HAR	RIETT	POE			
		19a. Informant's Name/Relationship (Type, Print) AUDREY SMITH WIFE		BRUCE ST				-	wn, State, Zij	Code)
More, N Pages 1 and nent of Health nnt: If item 27 ury or other tr		20a. Method of Disposition 1 Burial **Cremation 3 Removal from State* 4 Donation 5 Other (Specify)	f Dispo	sition (Name of natory or other place		Da	-		on - City or To	own, State
Baltimol permit. Pages Department of Important: If it any injury or o		`4 □ Donation 5 □ Other (Specify) 21. Signular of Funeral Service Liceusee, s		Y CREMATO				SYKESV	ILLE,	MD
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To t To t	Σ	29b. Signature and title of certifier		29c. License	number	08		29d. Date sig	gned (Month,	Day, Year)
3		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) 3900	(Туре,	Print) X/A/A Ball	16,RI	ens	SI	-/AO	2/2	P
Sta Registr		31. Date filed (Month, Day, Year) MAR 0 3 2005	A	books			-			

			For State Registrar		-			/ Depa		of H	ealth a	and Mo	ental Hyg		4000	071	50
	Physici		1. Decedent's Name (First, Mic Marie C. Si										2. Date of Dea Month Februar	ith Da		3. Time of 1:35	
0	/Medic Examin		4a. Facility Name (If not institu	_					4b. City, T		Location			~	. County of Dea	th	, д
	Funeral		Greater Balt: 5. Social Security Number	6. Se			lente In yrs. las		If Under 1		If Under	24 Hrs.	8. Date of Birth (Month, Day	h	Baltime 9. Bir		r Foreign
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	yland		10a. State 10b. Coul	•		1	Oc. City, 1	Town or Loc								10d. Inside Cit	y Limits
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c)	within 72 hours after death with the Maryland Johe. rthen "neturel", or Items 23s or 28s-1 show the Medical Examiner must be notified at	Be Completed by Funeral Director	10e. Street and Number 1805 Parkvu	e Roa	ad				10f. Zip (Code	2104	7		10g. Cit	tizen of What C		
\circ	after deal or items ? minst ma	uner	11. Marital Status		12. Was Dec	orces?	er in U.S.	13. V	/as Decede Yes, speci	ent of Hi fy Cuba	spanic Ori n, Mexicar	igin? (Spec	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whi		
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P.O. Box 68760	Hospital or Attending Physicien: The law requires that the death certificate be executed 14 hours after death. Funerel Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2		oirth 2 i	pregnanc Fetal de ne of deat	eath 3 🗆	Ectopic pre Other (spe						23d. Date of de Month		ear
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State of Maryland / Department of Health and Mental Hygiene 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Sliva Joshua Thomas February 28. 2005 2:00 A /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Middle River 1118 Orems Road If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) April 10, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10**X**M 2□F 015-64-9860 25 10.1979 Pennsylvania Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "natural", or frems 23a or 28a-f show 1 ☐ Yes 2 No Middle River Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1118 Orems Road 21220 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 11. Maritat Status filed within 72 hours after Hygiene. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Church Missionary n and Mental Hygien 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked oth any injury or other traumatic event pice. Be Beverly Jouce Nahas Thomas Francis Sliva 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1118 Orems Road, Middle River, MD Mr. Thomas Sliva (father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 3/2/2005 Oak Lawn Cemetery Baltimore. Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause out ach line. Immediate Cause (Final disease or condition resulting in death) HOS **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for Month Day Year 5 Other (specify) ☐Yes 2☐No detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 2☑No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide To the Hospitel Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature ar D30149 302 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar

amend item#5, perFh, 6845, 7/25/05 TT State of Maryland 7 Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 28, **Physician** Resham February Singh 2005 3:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dulaney Towson Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 8, 1948 Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 56 Director Indîa Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No NY n/a East Elmhurst 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 7714 25th Ave. 3rd Floor 23a 11373 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: tems 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bartender Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Karnail Singh Channan Kaur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lakhbir Singh/Brother-in-Law 79-11 41st Ave. Apt. B-516 Elmhurst, NY 11373 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of P Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Svc. Corp. 03/02/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fundral Service I censee Stephen D. Coster 1050 York Road, Towso, Maryland 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Inharronne resulting in death) /Medical Due to (or as a consequence of): Examiner resovam Sequentially list conditions, Due to (or as a consequence of): Examiner n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as i) sequence of): that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. anding physicien use as the buria Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD WAS 2128/65 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Fr Smte 308 Balt my 21201 Enlow H4714W1 821 N 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 03 2005 Registrar

			1 - For State	State	of Maryl		artment of F tificate of		Mental Hy	-	2005	07153
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			Southern Mary	land Hosp	ital		Cli	nton		Pri	ince Geo	orge's
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UNISION	or At after of Direct in by	Certification:	4 Homicide determi	ned 288. Plac	e of Injury - A ling, etc. (Spe	it home, farm, stre ecify)	eet, factory, office		28f. Location (City or To		Number or Rura	l Route Number,
	spital ours ours reral filled		29a. Certifier 1 1 Certifvin	g Physician: To th	e best of my	knowledge, death	occurred at the tin	ne date and place	e and due to the	cause(s) ar	nd manner as et	atod
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical I	xeminer: On the	pasis of examiner stated.	ination and/or inv	estigation, in my o	pinion, death occ	curred at the time,	date and pl	ace, and due to	the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 2 1 15 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedeni's Name (First, Middle, Last) Day **Physician** Sain 25,2005 5:02PM February Wallace Nevin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Dale of Birth (Month, Dey, Year) Feb. 13,1925 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 € M 2 □ F Yrs. 578-20-9266 80 Washington DC Director Usual Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or itams 23a or 28a-f shov other traumatic event, it a Medical Exartainar rulat be inclified at 1 ☐ Yes 2 🔀 No Directo Maryland Charles Cobb Island 10g. Citizen of Wha! Country? 10f. Zip Code 10e. Street and Number U.S.A. P.O. Box 8 20625 death Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1√7¥es 2 No IFYes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1942-1952 1 ☐ Yes 2√€ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Manager Recreational 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Sain Hilda Kelly ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health Tracy Sain (Daughter) P.O. Box 8 CobbIsland, Maryland20625 March 7,2005 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cemetery Cheltenham, Maryland * 4 ☐Donation 5 ☐ Other (Specify) Lee Funeral Home, Inc. 22. Name and Address of Facility 21. Signalus of Funeral Service 6633 Old Alexandria Ferry Road Clitnon, MD20735 M00259 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ocardi /Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Munknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1 Yes 2 ZINO or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending s after death.
If Director: Aff 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide within 24 hours a Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 00037066 02-26-2005 6188 Oxon of person who completed cause of death (Item 23a) (Type, Print) paigheogu, 32 Registrar's Signature Pay Year) State Garle Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end item 19a per fh 9841 3-3-05 Vt State of Maryland? Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 26,2005 11:16 Hunael Scher eprodry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore, MD Hospital Maryland N/A University If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. MAY 14, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**∑**M 2□F Months 50 219-60-2147 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 ¥ No BALTIMORE TOWSON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8205 ALSTON ROAD 21204 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nt: If item 27 is marked other then "naturel", or Itel 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No WHITE ģ Specify: Specify: 3 Widowed 4 Divorced Year or Dates: Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LAWYER LAW 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **SCHER** DORIS BUCHER IRVIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE JULIE SCHER / WOFE 8205 ALSTON ROAD - TOWSON, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or BETH ISRAEL CEMETERY 03/02/05 SALISBURY, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): Bcell lymphoma disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. λq 3 Probably 4 Unknown 2 No 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗌 No 1 Yes 2 NO 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury completely filled in by the funeral 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After (Month, Day Year) 5 Pending investigation 1 Tyes 2 No М death. Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide To the Hospitel within 24 hours To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. icai 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 26,2005 Kelonary

DHMH 17 Rev 1/2001

State

Registrar

BATIMORE, MD 21201

GREENE ST

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

23

LISE ASARO, MD

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tem 26 per phys 9841 3-3-05 vt State of Maryland 2 Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year LYNN SHOCKET MARCH 2005 10:38 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 107 WIMBLEDON LANE OWINGS MILLS BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR. 23, 1954 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1□M 2₩F 214-66-5402 Yrs. Director 50 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow 7 is markad othar than "natural", or items 23e or 28e-f ehov traumatic event, I're Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD BALTIMORE OWINGS MILLS 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 107 WIMBLEDON LANE 21117 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, i filed within 72 hours after di I Hygiene. othar than "natural", or Item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESPERSON rmit. Pages 1 and 2 should be itiled wi spartment of Health and Mental Hygien portant: if Itam 27 Is markad othar th y injury or other traumatic event, Ita TELEMARKETING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **EDWARD** BAUMEL ပ JANICE COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD BAUMEL / FATHER 107 WIMBLEDON LANE - OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. MIKRO KODESH BETH ISRAEL 3/2/2005 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fureral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ronam /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence Examiner to the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 22 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 220 ER/Outpatient 3 ☐ DOA Other: P 1 ☐ Yes 2 2No 4 Nursing Home 5 X Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C 🔀 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) of person who co

Registrar

DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 10f, 19b, 20b per fh 8841 3-3-05 vt.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	CIKI ICE	State of	Marylar				lealth Death						
			Decedent's Name (Firs	, Middle, Last)					- Catri		2. Date of De	ath	1005	8. Time of De	ath
	Physici /Medi		Avrohom		Sachs			,			ď	Month	Da	200	- 15.22	
	Examir	ner	4a. Facility Name (If not in Sinai Ho	stitution, give		Balt	imore	-	4	r Location			40	:. County of De	ath	
	Funeral Director		5. Social Security Number 220-53-02	6. Se:	X M 2□F		last birthday) 6 Yrs.	If Und Months	Pr 1 Year Days	If Under Hours	Min.	8. Date of Birt 1/03/I	999	9. B	irthplace (State or Fo	oreign
	ъ		Usual Residence of Dece			10c. Ci	ity, Town or Lo	ocation							10d. Inside City L	imits
	a-f sho	ctor	MD	N/A	1		ALTIMOR								1 Yes 2[
	with the	Funeral Director	10e. Street and Number	A1/E11/E				10f. Z	ip Code	_	211	209	10g. Ci	tizen of What (·	
	s 23	erai	2710 HANSON	AVENUE	12. Was Dece	dent Ever in I	18 13	Was Doo	ZIZI	ispanio Or		cify Yes or No		U.S.A		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam is a must be incitified at once.	þ	1 Never Married 2 3 Widowed 4 D		Armed For 1 Yes If Yes, Give Year or Da	cess? 2 [^] No 9		vvas Dec lf Yes, sp 1 ☐ Yes	ecify Cuba	Specify	n, Puerto F	Rican, etc.)	-	Black, Wh		
15-0	"natur	ieted	15. D (Specify onl	ecedent's Edu highest grad	cation e completed)		16a. Dece	kind of w	ork done	during mos	st of workin	g	16b. K	(ind of Busines	s/Industry	
21215-0036	filed within Hygiene.	Completed	Elementary/Secondary	(0-12)	College (1	4or 5+)	NON		use retired	")			NON	E		
Maryland	should be filed withir nd Mental Hygiene. marked other than imatic event, in M	To Be	17. Father's Name (First, DAVID	Middle, Last)			SACHS			18. Moth		(First, Middle,	Maider		POLLACK	
lary	2 should and Men Is marke aumatic		19a. Informant's Name/R	elationship (Ty	rpe, Print)		19b. Mailir	-		and Numb	er or Aural			or Town, State,	Zip Code)	
e, N	1 and Health Iom 27 other tr		DAVID SACHS 20a. Method of Dispositio		IER	20b.	2710 Place of Dispo cemetery, cree				BALT	IMORE,		21215 ocation - City o	21209 or Town, State	_
Baltimore,	Pages nent of ant: # ii ury or o		1 X Burial 2 ☐ Crei 1 4 ☐ Donation 5 ☐ C		Removal from S		UDATH #	DRAE	L CO	NG. O				EDALE,		
Balt	permit. Pages 1 and 2 Department of Health a Important: if item 27 Is any injury or other tra <u>once.</u>		21. Signature o Funeral	Service Licens	utter	^								N BROS. SVILLE,	, INC. MD 21208	
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	/Medical Examiner		resulting in death) Sequentially list condition		Du to (ctio re	spirat	•	1	cres	t				5day	5
8	uted d ansit	miner	f any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (mas a consec mon a	quence of):		osi:						5 year	rs
30,	icate be executed physician and s the burial-transit	i Examin	resulting in death) Last	(or as a consec	uence of):	_			12.011	C (5,500	~
68760,	.= 40	edicai			d Crie	mothu	rapy	10	Y V	iaba	Lorny	osarc	cm	هـ	o gent	2
.O. Box	The law requires that the death certific. Ite has been signed by the attending pl page 2 should be detached for use as i	Physician/M	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 Yes 2 No 9 Unknown	CATTL		rth 2□Feta unt at time of d	al death 3 🗌	Ectopic Other (s	pecify)				A	23d. Date of de Month	elivery Day Year	r
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<u>ra</u>		a	25. Was case referred to	medical						26 Place	e of Death	1 ☐ Yes (Check only o	2 Y No	1 🗆 Ye	s 2 No	
of Vital	Physician: this certificantal director,	To B	examiner? 1 🗌 Yes 2 2 No	F	lospital:	patient 2	ER/Outpatien	t 3 🗆 D	OA Oth	00				6 □Other (Sp	ecify)	-
0 00			27. Manner of Death 1 Natural 5	Pending	28a. Date o (Month	f Injury n, Day Year)	28b. Time of Injury		28c. Injun World	/ at </td <td>28</td> <td>Bd. Describe h</td> <td></td> <td></td> <td></td> <td></td>	28	Bd. Describe h				
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident 3 Suicide 6 4 Homicide	investigation Could not be determined	28e. Place buildin	of Injury - At h g, etc. (Speci	ome, farm, str	M eet, facto		Yes 2		Bf. Location (S City or Tow			Rural Route Number,	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 0 0	ertifying Phys	sician: To the	best of my kno	owledge, death	occurre	at the tim	ne, date ar	nd place, ar	nd due to the d	ause(s)) and manner a	as stated.	
	thin 24 thin 24 the F mplete	Medicai	one) 29b. Signature and title of		and mann	er stated.			c. License		- Cocuire			te signed (Mor		
)	\$ 7 K 7		Page 16	731	115 Ma	a mi)			7/3	28			Th 1,2		
	5		30. Name and address of	person who co				Print)				2 2	- ز ا		Md. 2121	
	Sta	te	Charlotte E 31. Date filed (Month, Day	LICKSYN	32. Rg	pisitar's Signa	ature	١٩٧٤	uere	rwe) 0	α , O	uti	MIOR.	11/d. 4121	5
	Registr				100		20	1 1								

			1 - For State Registrar	State of Mary		artment o			nd M		giene Reg. No. 0	05	07158
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	/Medic	-	Blanche Margarit 4a. Facility Name (If not institution, give			4b. City, To	wn, or L	ocation of		februar '		y of Death	3 10 .
	Examin	er	-	e Hospita	الم	1		ale			Bo	atio	nore
	Funeral Director		5. Social Security Number 6. Se		73 Yrs.	If Under 1		If Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da April	y, Year)		place (State or Foreign ntry) yland
	P .		Usual Residence of Decedent	146	c. City, Town or L	nantion.							Od. Inside City Limits
	Marylar f show	tor	10a. State 10b. County Maryland		Balti							A-Villelling and a second	1 XYes 2 No
	r 28a	irec	10e. Street and Number			10f. Zip Co	ode				10g. Citizen of	What Cour	ntry?
	th with	al D	830 Seneca Park	Road			212	220			US.	A	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event, the Medical Enantical must be inclified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deceden If Yes, specify 1 ☐ Yes 2 5		panic Orig , Mexican, Specify:	jin? (Spe , Puerto F	cify Yes or No Rican, etc.)	- 14. Ra Bla Speci	ce - Americ ack, White, fy: Wh	
21215-0036	thin 72 hou e. an "natura Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual (kind of work of DO NOT use	done du		of workir	g	16b. Kind of 8		dustry
2	ed wii	Con	12		Home	maker		10. 14-45-	de Maria	(Fine A. Adistrilla	Own He		
Maryland	lid be fill lental H ked oth	To Be	17. Father's Name (First, Middle, Last) August Henry Spli	edt, Sr.			'				Maiden Suma Sie Llo		
ary	should Name	-	19a. Informant's Name/Relationship (7	ype, Print)							er, City or Town		Code)
	and 2 saith in 27 i		James T. Swisher,					Cour			ce, MD		
Baltimore,	ges 1 t of Hi if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐			matory or othe	er piace)			ate	20c. Location		
ţ,	tment: tant:		'4 □ Donation 5 □ Other (Specify		Oak Lawn	2. Name and			3-4-	05	Balti	more,	
Ba	permi Depa Impo any ii		21. Signature of Fundral Service Licens	1200 10 1	М	CComas	Fhin	eral	Home	e, P.A.	rdon. M	210	09
60	Physician		23a. Part 1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	dications that caused the	e death. Do not en	iter the mode of	of dying,	such as	cardiac o	respiratory a	rrest,		Approximate Interval Between Onset and Death
,8760,	death certificate be executed e attending physician and identificate as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Corona do Due to (or as a corona do Due to (or a) do	onsequence of):	tery	D	ise	as	<u>e_</u>			
P.O. Box 6	death certif e attending ed for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	∃Fetal death 3	⊒Ectopic preg ☐ Other (spec						ate of deliv	ery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but r	not resulting in the	underlying cau	se given	n in Part I.			obacco use co <i>i</i> Yes 2 □ No	ntnbute to t	he cause of death?
Vital Records,	е <u>г</u> е	Completed				***********				24a. Was autor perfo		Were autoprior to codeath?	opsy findings available impletion of cause of
ita	ysician: This certificate director, pag	Be (25. Was case referred to medical examiner?				_		of Death	(Check only o	оле)		
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ion	Attending r death. sctor: After	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Injury	М	Work?	es 2 🗆 l	No				
Division of	l or Attendated after deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, s Specify)	treet, factory, o	office		2	28f. Location (a City or To	Street and Nun wn, State)	ber or Run	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Co		ysicien: To the best of r niner: On the basis of ex and manner stated	amination and/or in								
	o the ithin o the omple	Med	29h Signature and title of certifier				License				29d. Date sign		
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			30. Name and address of person who	completed cause of deal	h (Item 23a) (Type	, Print)							
	5			9000 Fran 32. Begistrar's		are Dr	ive	Bo	alti	nore	Maryl	and	21237
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 3 2			and a							

DHMH 17 Rev 1/2001

Swisher

		1	For State of N	laryland / Department of H Certificate of		ygiene 05 07159
L	Physicia		1. Decedents Name (First, Middle, Last)	mpsm	2. Date of Month	Day Year 15-5-0
)	/Medic Examin		ta. Facility Name (If not institution, give street and number	4b. City, Town, o	r Location of Death	4c. County of Death
	Funeral		Bon Secour Hospital 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday) Out fin	If Under 24 Hrs. 8. Date of (Month,	Birth 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Location	W-1.7	10d. Inside City Limits
	Maryle a-f sho		MD Baltimore	Randallstown		1 ☐ Yes 2 ☑ No
	with the a or 28, be not	Funeral Director	10e. Street and Number 5412 Old Ct. Road	10f. Zip Code 21133		10g. Citizen of What Country?
	death sms 23	neral	11. Marital Status 12. Was Decede Armed Force		Hispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
39	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 Is marked other than "natural; or Items 23a or 28a-f show other traumatic event, If a Madical Examinar must be notified a	þ	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	1 L Yes 2 L No	Specify:	Specify: Black
2-0	"natura	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of working d)	16b. Kind of Business/Industry
2121	d within giene.	Completed	Elementary/Secondary (0-12) College (1-4	TV Repairm	ian	Purple Heart
Maryland 21215-0036	t be filed ntal Hygi ed other	e	17. Father's Name (First, Middle, Last) Roman Thompson		18. Mother's Name (First, Mid Mamie Brewst	
aryl	and Men s marke	2	Roman Thompson 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street	.0 / 1	mber, City or Town, State, Zip Code)
	1 and 2 Health em 27 I		KOSCOL Thompson 20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	ng Rd. Apt. 10	20c. Location · City or Town, State
Baltimore,	0 0		1 Burial 2 □ Cremation 3 □ Removal from St. '4 □ Donation 5 □ Other (Specify)	Chownsy. He Cemeter		Crownsville, MD
Balti	permit. Pages 1 al Department of Hea Important: if item any injury or othe once.		21. Signature of Frheral Service Lice 15	22. Name and Addr	•	n Pass Balto mo 21229
			23a. Part / Enforthe disease, or complications that caushock, by near failure. List only one cause on each	sed the death. Do not enter the mode of dy h line.	ing, such as cardiac or respirator	ry arrest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	mary artery diseas	٤,	
	/Medical Examiner		Convertibly list conditions	as a confequence of): ensive a twisclerotic	Continuoscular	disease.
V	led isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause interest ideas in doubl) last	as a consequence of):		
, 0	cate be executed physician and the burial-transit	Examine	that initiated events c. Due to (o	as a consequence of):		
09289	ficate be physical	edical	d			
Box (w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant 1 Live bir	me of pregnancy h 2	су	23d. Date of delivery Month Day Year
P.0.	hat the d	Phys	9 Unknown Part II. Other significant conditions contributing to dea		given in Part I. 23e. [Did tobacco use contribute to the cause of death?
rds,	quires the signer of signer of signer of the contract of the c	ed by	End stage Kenul diseas	٤.		T☐Yes 2☐No 3☐Probably 4☐Unknown
Records,	e taw has b	Completed by	,			Mas an autopsy serior findings available prior to completion of cause of death? es 2 2 No 1
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner? Hospital:	patient 2 ER/Outpatient 3 DOA	26. Place of Death (Check o	nfy one) Residence 6 □Other (Specify)
Jo L		on: To	27 Manner of Death 28a, Date o	Injury 28b. Time of 28c. Injury W	ury at 28d. Descriork?	ribe how injury occurred
Division of	or Attending Phater death. Director: After thin by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, street, factory, office, etc. (Specify)	□ Yes 2 □ No e 28f. Locati City o	ion (Street and Number or Rural Route Number, r Town, State)
٥	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	calCe	29a. Certifier (Check only (Check only 2 Medical Exeminer: On the ba	pest of my knowledge, death occurred at the sis of examination and/or investigation, in my	time, date and place, and due to pointion, death occurred at the t	the cause(s) and manner as stated. ime, date and place, and due to the cause(s)
	To the H within 24 To the Fi complete	Medical	one) and mann 29b. Signature and title of certifier	er stated.	nse number	29d. Date signed (Month, Day, Year)
	F > F ŏ		ruly of redical	House officer D	45148	Jehruany, 27, 2005
	241		30 Name and address of person who completed cause	of death (Item 23a) (Type, Print) OUVS HOSPITAL, 2000 WES	t Bultimore Street	Tehrwany, 27, 2005 T, Baltimore, Hoyland 21223
	S	tate	31. Date filed (Many) Cay, Year 2005	igistrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Day Year Month Physician 13:01 07 avo; DAUID /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMOR MARU LAND OF UNIVERSITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number **Funeral** Days Months Hours **X**M 2□ F 47 MD Director 216-68-3065 06 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Exerciter must be notified at 1 X Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 21223 U.S.A. Lombard Street 1012 West Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 ☐ Married 1 ☐ Yes 2√ No Baltimore, Maryland 21215-0036 Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AWW Inc. Truck Drive 12th grade na 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Evelyn Woodings John A. Towler 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Towler-Sister 3805 Dolfield Ave, Baltimore, Md 20c. Location - City or Town, Slate 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or one King Memorial Park 3/5/05 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West Brayla Millan 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused lhe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) スエス HOURS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No ō 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Dther significant conditions contributing to death but not resulting in lihe underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nonknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed Yes 2 🗆 No certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner Other: 4 Nursing Home Hospital: 5 Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 this After thi 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannet of Death 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 🗌 Homicide hours after within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number

B State 29b. Signature and title of dertities

SEAN

31. Date filed (Month, Day, Year)

MAR 0 3 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2. Registrar's Signature

NORDT

Division of Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001 Wer we

XIRORT

of MARYLAND 21202

UNFURNITY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 15 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MÄRCH 2005 LOUISE THOMPSON L. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) TOWSON BALTIMORE BLAKEHURST 8. Date of Birth (Month, Day, Year) 11/17/1914 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Hours Months Days Min. 1 □ M 2 1 F 90 168-07-3740 PENNSYLVANIA Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No TOWSON MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1055 WEST JOPPA RD 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 4 YRS Elementary/Secondary (0-12) HOUSEWIFE HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CONSTANCE MORRISON JAMES LIPPINCOTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DAVID F. THOMPSON(SON) FOR EMBARCADERO CENTER SAN FRANCISCO, CA. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State GREEN MOUNT CREMATORY03/03/2005 BALTO CITY, MD. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO. 21. Signature of Funeral Service Licensee 16924 YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mer disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 X No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) **₹** No 1 🗌 Yes 28b. Time of Injury Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 Pending 2 □ No 1 Tes investigation

/Medical Examiner Examine The law requires that the death certificate be executed burial-transit Box 68760, Physician/Medical use as the signed by the a d be detached f P.O. I Records, Completed by Division of Vital Hospital or Attending Physician: Be ٩ dir Certification: death. þ

Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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238

other traumatic event, the Medical Examiner must be notified at

ö permit. Page Department of Important: If any injury or once.

Physician

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or Items 23.

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

hours after deat

within 24 hours a To the Funeral L

100

State Registrar

31. Date filed (Month, Day, Year) 3 0 MAR

Name and address of person

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 THomicide

(Check only one)

6 Could not be determined

completed cause of death (Item 23a) (Type, Print) LEHHAT, ITMO

2005

Begistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

6301 N CHARLES ST BALTIMORE MD 21212

29d. Date signed (Month, Day, Year)

			State of Maryland / Department of Health and N	-		•	0.7	100
			Registrar Certificate Of Death	2. Date of De	Reg. No	<u> </u>	U /	07
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Month	Da	Yeer Yeer	3. Time of I	
	/Medic		George McCellan Winter, Jr. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	March 1		. County of Death	8:15	a ^M
	Examin	er			40			
			710 Eastern Boulevard Essex 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bir	th	Baltimor 9. Birtho	e lace (State or try)	Foreign
	Funeral Director		220–22–1979 XM 2 F 78 Yrs. Months Days Hours Min.	Jan. 6,	y Year)	7 Penns	ylvani	а
			Usual Residence of Decedent	,				
	ylan		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City	
	e Ma	cto	Maryland Baltimore Perry Hall				1 🗌 Yes	XNO
	or 28	Directo	10e. Street and Number 10f. Zip Code		-	tizen of What Cour	try?	
	death with the Maryland ims 23e or 28e-f show	ral	8926 Cowenton Avenue 21128			S.A.		
	er de Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1945— IT Never Married 250 Married 15 EVers 2 DNo 15 Person 15	ecity Yes or No Rican, etc.)	-	 Race - America Black, White, 		
5	rs aft	by F	1 □ Never Married 2⊠ Married 1 □ Yes 2 □ No 1943 − 1 □ Yes 2 □ No 1945 − 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ Yes 2 □ No Specify: 1 □ Yes 2 □			Specify: Wh	ite	
Maryland 21215-0030	in 72 hours after death with the Marylar "naturel", or Items 23a or 28a-f show kolical Estuniner must be notified at				16b. K	(ind of Business/Ind		
2	in 72 n "ng Madik	plet	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	king				
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פ	be filed within 72 hours after tal Hygiene. d other than "natural", or Ite event, Ite Medical Exercitie	Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,	Maider	n Sumame)		
<u> </u>		To	George McCellan Winter, Sr. Ida Pott					
a	0 4 2 0		19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) 19b. Mailing Address (<i>Street and Number or Rus</i>		_			
	and lealth m 27 her tr		Helen Winter (Wife) 8926 Cowenton Avenue, 20a Mathod of Disposition 20b. Place of Disposition (Name of	Perry H		ocation - City or To		
ğ	Pages 1 nent of H ant: If ite iry or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, Crematory or other place)					-A
Baltimore,	t. Pa rtmen rtent:					ltimore,	-	na
g	permit. Pages Department of I Importent: If it any injury or of		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinsk	ci Funer	al E	Home, P.A		
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-	Physician		shock or heart failure. List only one cause on each line. Immedia Cause (Final disease or condition a. Mocality of the condition of the cause of the cause of the condition of the cause				Onset and D	reen leath
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Š	w requires that been signed b should be deta		Pate II. Other significant conditions continuing to about for rosating in the disconying cause given in a disconying				abiy 4 💢	,
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			25. Was case referred to medical 26. Place of Dea		2/CX:No	1 ☐ Yes	2□ No	
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ō	g Phy er this eral d	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Model?	28d. Describe			, 200-11	
0	utending P death. ctor: After I y the funera	atio	¹XXNatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No					
Division of	r Attener deatl	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (. City or Tox		nd Number or Rura e)	l Route Numb)8 <i>1</i> ,
ā	rs aft al Di							
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) (Check only one)					
	o the	Mec	29b. Signature and title of certifier 29c. License number	T	29d. Da	ate signed (Month,	Day, Year)	
	- s - ö		Aharan Balanson MiD. D005515	7	2	3/2/05	-	
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
_	2		70 10000	201				
* -	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Regist	al	MAK U. O. /111/2 Stateman B. Amarile 1					

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			State of Maryland / Department of Health and Me 1- State Registrar Certificate of Death		ene 0 0 5	07163
				Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Daniel Gary Warren	larch	1 2005	249 PM
	Examin	or	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	
			Franklin Square Hospital Rosedale		Baltin	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day,)	(ear) 9. Bir	thplace (State or Foreign buntry)
	Director	-	214-44-6755 57 Trs	9/6/194	/ Mai	cyland
	yland Iow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Man 9-f sh ifled	ţō	Maryland Baltimore Essex			1 ☐ Yes 2 No
	or 28	lrec	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	ountry?
	23e (23e)	a	423 Riverside Drive 21221		J. S. A.	
	tems	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Cuban, Mexican, Puerto Richard Company)	fy Yes or No- can, etc.)	14. Race - Ame Black, Whi	
36	s afte	by Fu	1 □ Never Married 2 Married 1 □ Yes 2 □ No 1966 1 □ Yes 2 □ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates: 1972		Specify:	
21215-0036	72 hours after deeth with the Maryland natural, or Items 23e or 28e-f show dical Examination outfiled at	pa	15 Decedent's Education 16a, Decedent's Usual Occupation	16	Bb. Kind of Business	nite /Industry
15	n "na	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	'		•
212	filed within Hygiene. Ither then "	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief Engineer	I	Hospital	
	be filed tal Hygi d other event.	ВеС	17. Father's Name (First, Middle, Last) 18. Mother's Name (I	First, Middle, Ma	uiden Surname)	
<u>la</u>	should be and Mental is marked o	2	Lee Roy Warren Edna Mae I	Hampton		
Maryland	and and ls m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural F	Route Number, (City or Town, State,	Zip Code)
	os 1 and 2 of Health item 27				cyland 212 oc. Location - City or	
altimore,	0 0		1 № Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)	/4	,	
ij	t. Pa rtmen rtent: rjury			005 <u>B</u> a	altimore,	Maryland
Bal	permit. Page Department Importent: If eny injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral I 1407 Old Eastern Aver	Home PA nue Ess	sex, Mary	and 21221
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	es the gned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			the cause of death?
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ec	law ras be	Completed		24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of
======================================	The cate h	Cou		1 Yes 2	No 1 Yes	2 🗆 No
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Division of Vital Records,	dlng I h. After funer	tion	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work?		,,	
İSİ	Attended death ctor:	lical	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28		et and Number or R	ural Route Number,
Dis	after after Dire	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town,	State)	
	hours nerel y filler		29a. Certifier 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the cau	se(s) and manner a	s stated.
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical	(Check only 2 Medical Examiner) On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	With To 1	Σ	29b. Signature and title of certifier 29c. License number		1. Date signed (Moni	
	2 1		D54725		3/1/2005	
	12+1		30. Name and address of po son who pleted cause of death (Item 23a) (Type, Print) DR JCSe . ODE Z 9000 Franklin Square Drive Baltimore	r 0 4	incula sel	21237
	1 1 1 1 1		30. Name and address of no son who plet-d cause of death (Item 23a) (Type, Print) DR JCSC LOPEZ 9000 Franklin Square Drive Baltimod 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 3 2005	- 1	Tell y loctice	2,001
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			1 - For State Registrar	State of Ma	•	epartmen Certificate				jiene	05 07161	
	Physici		Decedent's Name (First, Middle, La.		. WILL	_I AMS			2. Date of Dea		3. Time of Death	
	/Medio Examin		4a. Facility Name (If not institution, give Saint Joseph	e street and number)	Center	4b. City,	Town, or Lo	cation of Death		4c. County	of Peath altimore	
	Funeral Director		5. Social Security Number 6. S 214-20-1089	ex □M XXF	e (In yrs. last birti 82 Y	nday) If Under Months	er 1 Year If Under 24 Hrs. s Days Hours Min.		8. Date of Birth (Month, Day 09-10-	1922	Birthplace (State or Foreign Country) MARYLAND	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits	
	Ba-f sh	Director	MD. N/	A			ALTIMO	DRE			XXYes 2□No	
	th with ti	al Dire	10e. Street and Number 700 WEST 40t	h. STREET		10f. Zip	212	11	1	Og. Citizen of V	S. A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Madical Exactiner, ust be inclined any injury or other traumatic event, if a Madical Exactiner, ust be inclined anones.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ▼ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 XX If Yes, Give Year or Dates:		13. Was Deced If Yes, spec	ify Cuban, N	nic Origin? (Spec Mexican, Puerto R pecify:	cify Yes or No- lican, etc.)		ce - American Indian, ck, White, etc. by: BLACK	
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, Maryland	and 2 shou salth and M n 27 Is mar iar traumat	-	19a. Informant's Name/Relationship (JEAN S. BUSH (Турө, Print) DAUGHTER)	32	70 FLAX	TERRI	CE, BAL	TIMORE,	MARYLA	State, Zip Code) AND, 21209	
altimore,	Pages 1 ment of He ant: If itan ury or oth		20a. Method of Disposition XXBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		cemetery		ther place) EMETER	03 - 07			City or Town, State	
Ball	permit. Depart Import any in		21. Signature of Funeral Service Licer	R.G.	RUTH	RUCK T		FUNERAL	HOME, I	NI I	050 YORK ROAD USON,MD.21204	
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Vital	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	Place of Death	(Check only on	θ)		
J Of	Phys rthis ral dii	n: To	1 Yes 2 No 27. Manner of ath	1 Inpatie 28a. Pate of Injur (Month, Day	nt 2 ☐ ER/Outp y 28b. Ti 'Year) Ini		Bc. Injury at Work?	1 ☐ Nursing Home 28	e 5 ☐ Reside 3d. Describe ho			
Division of	death death ctor: / the	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	1	ıry - At home, farr	М	1 🗌 Yes	2 No 28	3f. Location (St. City or Town		er or Rural Route Number,	
_	To the Hospital or Al within 24 hours after of To the Funaral Dirac completely filled in by	Medical Co	29a. Certifier 12 Certifying Ph (Check only one) Medical Exam	ysician: To the best on niner: On the basis of and manner sta	of my knowledge, examination and ted.	death occurred a for investigation,	at the time, d in my opinio	ate and place, and n, death occurred	nd due to the ca	ause(s) and ma	inner as stated. and due to the cause(s)	
)	To th within To th, compl	Me	29b. Signature and title of cartifier	ev (10	29c	License nu		29	9d. Date signed	d (Month, Day, Year)	
	n		30. Name and address of person who				attice y one	a and seed to	July 1, 8 2000 man .	,, ,,		
	Sta	te	BOON P. IM M. I 31. Date filed (Month, Day, Year)		SLER D			I MARYLI	AND 21	.204		
	Registr	ar	MAR 0 3 2	105	r's Signature	Good						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:53 M Winters adiacos /Medical 4b. City, Town, or Location of Death Baltimore County of Death 4a. Facility Name (If not institution, give street and number) Examiner Posthmore University of Wanylound to If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1**X**M 2□F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depirtment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28e-1 show any injury or other treumatic event, I'm Medical Exercitive. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 ☐ Married 1 Never Married 1□Yes 2XNo Specify 3 Widowed 4 Divorced MHI16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DRIVER 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . MECHANICSVILLE, VA 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANATOMY GIFTS KEG 2124105 4 Donation 5 Other (Specify) 21. Signal of Fun 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasa 2601 Mountain Road 2601 Mountain Road - Pasadena, MD. 21122 Part1. Enter the diseas shock, or heart failure. ease, complication Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner mokin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consuluence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year Dav 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗌 No 3 ☐ Probably 4 ☐Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 1 Yes 2 No certificate 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one ≥X ER/Outpatient 3 □ DOA Other: 2 200 Hospital: Certification; To 1 🗌 Yes 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 8b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation 1 🗌 Yes 2 No Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

03

2005

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	Mental Hygier	.000 01100
	Physici	an	1. Decedent's Name (First, Middle, I	(A) I DOF		2. Date of Death Month	Day Year 3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or Location of Dea		4c. County of Death
H	Funeral		5. Social Security Number 6	Sex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign
	Director		217-24-9393 Usual Residence of Decedent	10 M 2×F 73	Yrs. Months Days 110013	4/9/19	31 GERMANY
	show a to	5	10a. State 10b. County	10c. City, "	Town or Location		10d. Inside City Limits 1 ☐ Yes 2 No
	th the M or 28a-f e routh	Irecto	10e. Street and Number	FURD U	10f. Zip Code	10g. C	Citizen of What Country?
	eeth wi	eral D	1004 BEAL 11. Marital Status	12. Was Decedent Ever in U.S.	21085	Specify Yes or No-	14. Race - American Indian,
36	s after d	by Funeral Director	1 Never Married 2 Married	If Yes, Give	13. Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 No Specify:	rto Rican, etc.)	Black, White, etc. Specify:
21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. ther than "natural", or lieme 23a or 28a-f show ther than "natural", or lieme 23a or 28a-f show ont, the Medical Exartinar must be rodified at	ted b	3 Widowed 4 Divorced 15. Decedent's (Specify only highest)	Education	16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking 16b.	Kind of Business/Industry
2121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMAKER	. 0	WN HOME
	d la b	Be	17. Father's Name (First, Middle, La	ER KREB	- 0	ame (First, Middle, Maid	en Sumame)
Maryland	2 should and Men is marke	ဥ	19a. Informant's Name/Relationship		19b. Mailing Address (Street and Number or F	Rural Route Number, City	y or Town, State, Zip Code)
	1 and 2 Heelth tem 27		JAMES WAU 20a. Method of Disposition	ACE SPOUSE 20b. Place	e of Disposition (Name of	Date 20c.	Location - City or Town, State
Baltimore	Pa ant ary		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe	city) ANA		8105 HF	ANOVER, MD
Ball	permit. Departrimporte any inju		21. Signature of Fundal Service Like	ense	22. Name and Address of Facility Daugherty Fart 2601 Mc	nily Funeral Home An ountain Road - Pasa	d Cremation Center, P.A.
	. 1		23a. Part1. Enter the disease, or shock, or heart failure. List on	implications that caused me death. It one cause on each line.	Do not enter the mode of dying, such as cardia		Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a consequen	nos of):		2 MONT41
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	nce of):		
	and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequer	nce of:		
8760,	ate be executed thysicien and the burial-transit			d			
Вох 68	death certifica attending phi d for use as th	/Med	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc			23d. Date of delivery
	The law requires thet the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 □ Yes 2 to No 9 □ Unknown	1⊡Live birth 2 □ Fetal de 4□Pregnant at time of deal 9□Unknown			Month Day Year
s, P.O	res thet the de signed by the a I be detached I	by Ph		s contributing to death but not resulti	ng in the underlying cause given in Part I.		o use contribute to the cause of death?
Records,	w require been signature	eted				1 ☐ Yes	24b. Were autopsy findings available
Re		Completed				autopsy performed? 1 ☐ Yes 2 1	prior to completion of cause of death?
Vital	Physician: The this certificete har ral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes	Hospital: 1 ☐ Inpatient 2 ☐ EF	Other	eath (Check only one) Home 5 Residence	6 ∏Other (Specify)
on of	iing Ph	lon; T	27. Manner of Death Datural 5 Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury at Work? M 1 Yes 2 No	28d. Describe how in	
Division	To the Hospital or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the fune.	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be one Bless of Injury At hom		28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
Ω	To the Hospital or Attenwithin 24 hours efter deat To the Funerel Director:				edge, death occurred at the time, date and place		
	the Ho thin 24 the Fu	Medical	(Check only 2 Medical Exone) 29b. Signature and title of certifier	aminer: On the basis of examination and manner stated.	n and/or investigation, in my opinion, death occ		and place, and due to the cause(s) Date signed (Month, Day, Year)
	⊢≯⊢ŏ		Dr. Purta	el Staff physic	un 019714	9	117/05
	3		30. Name and address of person wh	no completed cause of death (Item 2	3a) (Type, Print) - 4440 IEAITERY AVE	BALTIMIN	e md 2/224
	Sta Registr		31. Date filed (Month, Day Year)	32 Registrar's Signatur	3a) (Type, Print) - 4440 IZAITENY KVE	,	,

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		l	For State Registrar		State of M	laryland i				lealth a D <i>eath</i>	and Me	-	gien Reg. No	000		07	167
	0.	e ell		ne (First, Middle, La	ist)						2	Date of De	ath		V	3. Tim	e of Death
	Physici /Medio			A. Watso								rebrua		22, 2	005	04	:36P.M
	Examin	er		-	re street and number			-		r Location o	of Death		1	County o			
					d Hospital			If Under	Into	∩ If Under a	24 Hrs. 0	Date of Di		rince			
П	Funeral Director		5. Social Security 1		4514 OCT	ge (In yrs. last 34	Yrs.	Months	Days	Hours	Min.	Date of Bir (Month, Da lav 31	ıy, Year			ntry) bama	te or Foreign
			Usual Residence	700								<u> </u>	1 1 7 1				
	nylan how	_	10a. State	10b. County		10c. City, T		ation									e City Limits
	e Ma	Funeral Director	Md.	Prince (George's	Clir	nton										Yes 2 □ No
	ith th	Jire	10e. Street and Nu					10f. Zip					10g. C	itizen of Wi	nat Cou	ntry?	
	23a	rai	9405 Pi	n Oak Sti	reet				735					nited			
	r deg	ne	11. Marital Status		12. Was Deceden Armed Forces	? Activ	Active If Yes, specify Cuban, I					y Yes or No can, etc.))-	14. Race Black	 American American /li>		٦,
Maryland 21215-0036	4 within 72 hours after death with the Maryland Jiene. r then "netural", or Items 23a or 28e-1 show tre Medical Exercitivat must be trofilled at	Ď	XX Never Mar 3 ☐ Widowed	ried 2 Married 4 Divorced	1 ▼ Yes 2 □ If Yes, Give Year or Dates:	Dutv		☐ Yes	2¢CkNo	Specify:				Specify:	В1	ack	
5-0	72 ho	Completed	(Spe	15. Decedent's E	ducation ade completed)	1	6a. Deced	ent's Usua	al Occup	ation during most	t of working		16b. h	Kind of Bus	iness/In	dustry	
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2	75 15 15 15		17 Fether's Name	(First, Middle, Las	*1		Tec	ch Sg	t	18 Mothe	ar's Name //	irst, Middle		Forc	_		
anc	ould be fi Mental P arked ot atic ever	Be												ir Sbiriainio	,		
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	s 1 and 2 f Heelth Item 27 other tr	1 8	20a. Method of Dis	ameson/ M	lother	20b. Place	of Dispos	sition (Nar	ne of	- 1	e <u>rma</u> . Dat	Alah		ocation - C	ity or To	own, Stat	θ
Jor	Pages nent of int: If It iry or o		1 🖾 Burial 2	Cremation 3	Removal from State	9	etery, crem	•		·	2/5/	2005	17 1	1 8 0			.
Baltimore,	it. Pertime			5 Other (Speciumeral Service Liga		Pinev	iew (Name ar	ery	ss of Facilit	3/5/	2005 Funera	<u> </u>	ley C	ran	ie, A	Alabama
Ba	permit. Pages Department of Importent: If I any injury or o		21. Signature out	10190	MO	11/52	66	33 0	ld A	lexan	иder F	runera erry]	ar n	ome, Clint	on.	Md . 2	20735
	_		23a, Part1, Enter	the disease, or cor	nplications that cause one cause on each	ed the death. (Approx	mate
			shock, or he Immediate Cause		one cause on each	fine.	0 T										Between and Death
	Fnysician /Medical		disease or conditi resulting in death	on	a	etipi-	4	- MYC	EVIT	62					-		
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	ted	in in	Sequentially list c if any, leading to i Cause (Disease of	lartying or injury											-		
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9289	death certificate be e attending physicie od for use as the bui	Physician/Medical			0.												
×	r certif	Ž	IF FEMALE: 23b. Was decede	nt prognant	23c. If yes, outcom									23d. Date	of deliv	ery	
Вох	atter i for u	ciar	in the past 1:	2 months?		2 ☐ Fetal de at time of deatl		Ectopic po Other (sp		′				Mont	h	Day	Year
Ö	th the	ıysi	9 ☐ Unknow		9□ Unknown												
σ	that ned by deta		Part II. Other sign	ificant conditions	contributing to death	but not resultir	ng in the un	derlying	ause giv	en in Part I.		23e. Did	obacco	use contrib	oute to t	he cause	of death?
sp.	requires een sign hould be	d by										1 🗆	Yes 2	2 □Xvo 3	Prot	oably 4	Unknown
000	> 0 0	lete										24a. Was	an	24b. W	ere auto	psy findi	ngs available
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<u>a</u>	ician: Th certificate ector, pag	e Co	25. Was case refe	erred to medical						25 Diaco	of Dooth (1 Des	2 N	0 1	Yes	2□ No	
Vital	Physician: this certific ral director.	o Be	examiner?		Hospital: 1 🗀 Inpat	tiant 2 TVED	/Outpatient	3 🗆 ГУ	Oth	er		5 ☐ Resi		6 Other	/Snaci	64)	
of	Phys or this aral dia	1	27. Manner of Dea		28a. Date of In	jury 28	b. Time of		28c. Injun Wor	4 🗆 140		d Describe	how into	ILA OCCITUR	d		
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To the Hospitel or Atte within 24 hours after ded To the Funerel Directo completely filled in by th

Medical Certifi

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

State Registrar

Place of Injury - At home, farm, street, factory, office building, etc. (Specify).

City or Town, State) .5 at Schutz Kd

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

OCME

29d. Date signed (Month, Day, Year) February 23, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Feb 28, **Physician** 2005 Phillip Daymon Washington 11:06 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Southern Marvland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 18, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** XXM 2□F 78 1926 Maryland 170 20 1966 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f shov ulner towart to notified at 1 ☐ Yes ₹ No Director Prince George's Clinton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 20735 United States 8407 Echo Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status V Yes 2 No 1944 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 11 Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or any injury or other traumatic event, the Medical Exam once. Specify. Specify ð 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Government System Analyst 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elhania Washington Martha Jamison 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Washington (Wife) 8407 Echo Lane, Clinton, Maryland 20b. Place of Disposition (Name of commetery, crematory or other place) March 11, Arlignton National Cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandira Ferry Rd, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMBOLISM PULMONARY 2 WEEKS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MALIGNANCY Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ő 4☐Pregnant at time of death 5 Other (specify) ed by the detached Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEMIA 1 Yes 2 No 3 Probably 4 Unknown Completed need PAILURE HEART CONFESTIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate ! 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 2 1 npatient 2 ER/Outpatient 3 DOA After this ate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending 1 Natural after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D28281 FEBRUARY 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9131 PISCATAWAY RD, CLINTON, MD 20735 BENJERS, NELSON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year STEWART GORDON WELDON, JR. 2:35 A M 2005 March 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE OF BALTIMORE: GILCHRIST CENTER Towson
If Under 1 Year If Under 24 Hrs. Baltimore County 5. Social Security Number **Funeral** 6. Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M M 2□ F Months Days Hours Min Director 218-28-9330 May 29, 1933 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b Counts 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 21 No Maryland | Baltimore County 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a 6507 Sharon Road Completed by Funeral 21239 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 □ No Korean
H Hes, Give
Year or Dates: Her Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married ō 1 ☐ Yes 25 No Specify: 3 Widowed 4 Divorced White War 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Areospace Materials Traffic Manager 2 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H Is marked otl Stewart Gordon Weldon, Sr. Victorine Stirling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 Barbara F. Weldon (Wife) 6507 Sharon Road, Baltimore, Maryland 21239 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₹ <u>₹</u> 1 Burial 2 Tremation 3 Removal from State
4 Donation 5 Other (Specify)
21. Sinating 1 Funey I Sayide Litture 5 Green Mount Crematory 3/5/2005 Ealtimore, Maryland 22. Name and Address of Facility MarylandMarkin D. Lawson Mitchell-Wiedefeld Funeral Home, Inc. Mary latidMarkIn D. Lawson

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sportas cardiac respiratory arrest, Mary land shock, or heart failure. List only one cause on each line.

Interval Between Onset and Death Immediate Cause (Final Priysician metastat disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Hospital or Attending Physician: within 24 hours after deat To the Funeral Director:

Stawartt expire

Registrar

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifie

29c. License number 1175205 29d. Date signed (Month, Dav. Year)

of deam (Item 23a) (Type, Print) 30. Name and address of person

N. Chales St. Balte Md D120%

			1 - State Registrar		epartment of Health and I Ce <i>rtificate of Death</i>		ene 0 0 5	07170	
	T T		Decedent's Name (First, Middle, Last)			2. Date of Death	1	3. Time of Death	
	Physicia /Medic		JEAN KRAFT WALL	ACE		Februar	y 21, 2005	1:25 P ^M	
	Examin		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Deat	h	4c. County of Death		
			GENESIS ELDERCARE PER		Parkville If Under 1 Year If Under 24 Hrs.	D. D. L. of Birth	Baltimore	County	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last birth	rs. Months Days Hours Min.	(Month, Day,		place (State or Foreign htry)	
	ס		Usual Residence of Decedent			□Nov 16,	1919 Mar	yland	
	arylan show	_	10a. State 10b. County	10c. City, Town			1	Od. Inside City Limits	
	Ba-f	ecto	Maryland Baltimore (county Par	ckville			1 □ Yes 2 X No	
	with t	ä	1801 Wentworth Road		10f. Zip Code 21234	10	g. Citizen of What Cour USA	ntry?	
	ms 23	Funeral Director	11. Marital Status 12. Wa	as Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Americ		
5-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than 'natural', or itams 23a or 28a-f show at other than 'natural', or itams 23a or 28a-f show evant, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 I	med Forces?]Yes 2∭XNo /es, Give ar or Dates:	If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.)	Black, White, Specify: Whi		
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade com	oleted) 16a. I	Decedent's Usual Occupation Give kind of work done during most of work	rking 1	6b. Kind of Business/Inc	•	
2121	within the	ld m		llege (1-4or 5+)	life. DO NOT use retired)	-	Health Ca	ire	
2	filed Hygie thar ant, I	ပိ	11th 17. Father's Name (First, Middle, Last)	l OTA	aims Representative	me (First, Middle, M	Provider		
an	e d fa	To Be	Leonard Goheen Kraf	·r	Hulda	, , ,	Schanze		
<u>_</u>	ges 1 and 2 should t of Health and Men If itam 27 is merka or other traumatic	-	19a. Informant's Name/Relationship (Type, Pr		Mailing Address (Street and Number or Ru	ural Route Number,		Code)	
	1 and 2 Health arm 27 l		Charles Marlow (Neph		11 Park Street, Apt				
altimore,	Pages 1 nent of H int: if ital		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	al Iroin State	Disposition (Name of commatory or other place) Mount Cemetery 2/23		oc. Location - City or To Baltimore,		
Balt	permit. Pages Department of Important: if it any injury or o		21. Sign ure 11 ral Sivice Licensee Martin D. Lawson	\	22. Name and Address of Facility Mitchell-Wiedefeld	d Funeral	Home, Inc.	•	
	4		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do no	ot enter the mode of dying, such as cardial	altimore.	_{st,} Maryland 2	Interval Between	
F	Physician		Immediate Cause (Final disease or condition	ASC				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of);				
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	():				
/	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
ó	e exectan an an arial-tr			Due to (or as a consequence of	·):				
8760	icate be executed physician and s the burial-transit	edical	d						
			IF FEMALE:	res, outcome of pregnancy					
Box	death certific e attending p	Physician/M	in the past 12 months?	Live birth 2 Fetal death Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	nry Day Year	
o.	at the de I by the a stached	hys	9 □ Unknown	Unknown					
Records,	The law requires that the death certifie has been signed by the attending vage 2 should be detached for use a	by	Part II. Other significant conditions contributions Mayor Depre	ng to death but not resulting in	the underlying cause given in Part I. Aculeure to Thiri		acco use contribute to th s 2 ☐ No 3 ☐ Prob	0	
eco	law re as ber 2 sho	Completed	0			24a. Was an autopsy	24b. Were auto	psy findings available inpletion of cause of	
		Corr				perform	ed2 death?	2500	
Vital	iclan: Th certificate rector, pag	Be	25. Was case reterred to medical examiner? Hospita	1.	26. Place of Dea	ath (Check only one)		
ō	Phys r this ral dir	. To	TUTOS ZEINO	1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA 4 Mursing H	fome 5 Resider	nce 6 Other (Specify	/)	
0	nding th. : After s fune	tlon	1 Natural 5 Pending Accident investigation		me of 28c. Injury at Work! M 1 Yes 2 No	200. 2000. 20 110.	injury coodinod		
Division of	Attar or dea actor by the	Certification:	2 Could not be	. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura	l Route Number,	
ء	ital or rs afte rs al Dir led in	Cert	(- C Florinoide	building, etc. (Specify)		City of Town,	State)		
	To the Hospital or Attanding Physician: inin 24 hours alter death To tha Funaral Director: After this certified completely filled in by the funeral director; p	edical	(Check only Z Medicel Examiner: O	To the best of my knowledge, in the basis of examination and ind manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	e, and due to the cau urred at the time, dat	use(s) and manner as st te and place, and due to	ated. the cause(s)	
	To t	Σ	29b. Signature and title of certifier		29c. License number		d. Date signed (Month,	Dey, Year)	
			Mes	}	M DO05942	SF	Chruny 2	5 2005	
_	6		30. Name and address of person who complete Ndidi Feinberg, M.	1			0	9	
	Sta Registr		31. Date filed (Month, Dey Year) MAR 0 3 2005	32. Registrar's Signature	Soul .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Imer 0 Wheeler 28 /Medical 05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Chestertown Kent 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 **X**M 2 □ F 214-28-7906 72 Yrs. Director 1932 Maryland Maryland Queen Anne

10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Impurtant: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any njury or other traumatic event, the Mindfall Examinar recognitions. 10c. City, Town or Location 10d. Inside City Limits Centreville 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21617 USA 2635 Church Hill Rd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 → No If Yes, Give 1 Year or Dates: 950 – 53 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes 🏖 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Minister A M E Church 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Wheeler Mary Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances A. Wheeler(Wife) 2635 Church Hill Rd. Centreville, Md. 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Magnetery trempter (1920) 1 Burial 2 □ Cremation 3 □ Removal from State Beneficial Lodge#3 3-5-05 Centreville, Md. ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. Larry , Keese MOOY83 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial infarction disease or condition resulting in death) hrs /Medical Due to (or as a consequence of) **Examiner** 6nd STACE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque of): Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as attending a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) , the the P.O. 9□ Unknown 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 ☐ Yes 2 No 10 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No Diractor: 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 Homicide within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar FREUltrick

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

River Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

32. Redistrar's Signature

W

MAR 03

		•	State of Maryland / Department of Health and Mental Hygiene O 5 0 7 1 7 Certificate of Death Reg. No.	2
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Lloyd Dale Yoakum, Sr. 2. Date of Death Month Day Year 03. Time of De. 10:35	
	Examin Funeral Director	er	As. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4d. County o	o <i>reig</i> n
	rland ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City L	imits
	e Man ia-f sh	ctor	Maryland Baltimore Perry Hall	OME
	vith the	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	ns 23	Funerai	6 Ayr Court 21236 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? WWTT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 14. Race - American Indian, Black, White, etc.	
980	72 hours after death with the Maryland neturel', or Items 23a or 28a-f show disal Examinar must be notified at	by	1 Manital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 1 Never Dates: 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Mild. 1 Never Married 1 Never Mexican, Puerto Rican, etc.) 1 Never Married 2 Never Mild. 1 Never Married 1 Never Mexican, Puerto Rican, etc.) 1 Never Mexican, Puerto Rican, etc.) 1 Never Mexican, Puerto Rican, etc.) 1 Never Married 2 Never Mild. 1 Never Mild. 1 Never Mild. 1 Never Mild. 1 Never Mild. 1 Never Mild. 1 Never Mild. 1 Never Mild. 1 Never Mild. 1 Never Mild. 1 Never Mild. 1 Never Mild. 1 Never	
21215-0036	S - 3	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
	filed with Hygiene. other that	Be Co	7 Years Lineman American Can Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
/lan	2 should be f and Mental I Is marked of aumatic eve	To B	Orville Yoakum Ethel McKewan	
, Maryland	1 and 2 sho Health and i tem 27 is ma other trauma		19a. Informant's Name/Relationship (Type, Print) Lloyd D. Yoakum, Jr. / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Ayr Court Baltimore, Maryland 21236	
altimore,	00 0		20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 1 Dearton By Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Balt	permit. Pag Department Important: I any injury o		21. Synature of Juneal Strong	
	rnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute MI Due to (or as a consequence of): Sequentially list conditions	an ith
68760,	ficate be executed g physician and as the burial-transit	sai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying trace (Disease of Figure 1) that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	
P.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy bage 2 should be detached for use as thi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ır
	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deat 1 Yes 2 No 3 Probably 4 Probably	
Records,	siclan: The law requir s certificete has been si lirector, page 2 should I	Completed	24a. Was an autopsy findings ava prior to completion of caus death? 1	ulable se of
of Vital	Physiclan: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital: Other. Other.	
of	Physic r this or): To	27. Mannerof Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
ion	Attending F r death. ector: After by the funer	atlor	1 □ Aatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	
Division	el or Atte s after de el Directo	Certification:	3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined 5 Repeated a See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, office City or Town, State)	۲,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier (Check only one) 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the within 2 To the complete	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year)	
	let 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sun / Ahuja 9000 Franklin 3quare Drive Ba / timere, Hd 2/237	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 3 2005 Segretar's Signature Segretary MAR 0 3 2005	

Yochum, Lloyd

State of Maryland / Department of Health and Mental Hygiene 0 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 27, 2005 **Physician ZLOTAK** 2:15 P **ESTHER** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE JEWISH CONVALESCENT CENTER 8. Date of Birth Month Day, Year AUG. 15, 1916 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🔽 F POLAND 88 106-26-0432 Director Usual Residence of Decedent the Maryland 10d, Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examinar near be notified at 1 ☐ Yes 2 ☑ No Director BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò or Items 23a 10806 MEADOWLEA ROAD 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE Specify ģ 3

Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene important: if Item 27 is marked other than "n eny injury or other traumerin-Elementary/Secondary (0-12) Coilege (1-4or 5+) GROCERY / DELI PROPRIETOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ZLOTAK ZLOTAK** ADELA (UNKNOWN) 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10806 MEADOWLEA ROAD - OWINGS MILLS, MD 21117 ERNEST ZLOTAK / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MOSES MONTEFIORE CEM 03/02/2005 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): CELL CARCINOMA OF FACE Examiner UAMOUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of) P.O. Box 68760 attending physician 99 Physiclan/Medlcal the ! IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 2 ER/Outpatient 1 Tyes 20 No 1 Inpatient 3□ DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? o the Hospital or Attending Pt ithin 24 hours after death. o the Funeral Director: After th ompletely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2 To the 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number my veen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 7220 SNEEM 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 0 3 2005 Registrar

DHMH 17 Rev 1/200

ORIGINAL

			1 = For State Registrar	State of Maryl		artment of He	ealth and	•	giene	005	07171
	_		Registrar 1. Decedent's Name (First, Middle, Last,			Timeate of L		2. Date of De	Reg. No	000	3. Time of Death
	Physici							Feb.	Day	005	4:45an
1	/Medic Examin		Ronald Eugene Ar 4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Dea			unty of Death	4.45am
	CXAIIIII	eı	10 Benjamin Park			Port De				ecil	
	Funeral		5. Social Security Number 6. Sec	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hr			9. Birthp	lace (State or Foreign
	Director		215-58-0861	[M 2□F 53	Yrs.	Months Days	Hours Min	09/18	1951	Mar	yland
	pu »		Usuel Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo						0d. Inside City Limits
	ehor	ŏ									1 ☐ Yes 2X No
	the N	ect	MD Cecil 10e. Street and Number		Port Dep	10f. Zip Code			10a Citizan	of VAIIb at Court	
	with	ă		Duine		· ·			_	of What Cour	ury?
	eath	era	10 Benjamin Park	12. Was Decedent Ever	in U.S. 13	21904 Was Decedent of His	snanic Origin? (Specify Yes or N	USA	Race - Americ	an Indian
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", of Items 23e or 28e-f ehow any injury or other treumatic event, If a Medical Examinating met be multiped at once.	by Funeral Director	1X Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		If Yes, specify Cubar	Specify:	rto Rican, etc.)		Black, White,	
21215-0036	ural',	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 Hes 2/A 140	Specify.		Spi	ecify: Wh	ite
5-	72 h natu	Completed	15. Decedent's Edu (Specify only highest grad	cation completed)	(Give	dent's Usual Occupa kind of work done di	uring most of wo	orking	16b. Kind o	of Business/Inc	dustry
121	vithin ne. hen	mρ	Elementary/Secondary (0·12)	College (1-4or 5+)		DO NOT use retired)			DI		
20	iled v Hygie ther t		10th 17. Father's Name (First, Middle, Last)		Wa	rehouse	18 Mother's Na	ame (First, Middle			ompany
Maryland	ntal h) Be		bauab						naine)	
2	should nd Me mark matic	욘	Harvey Eugene Ar 19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street a		le Single		wn State Zin	Code)
<u>M</u>	id 2 s th an 27 is treu		Robert M. Arbaug	h SrBrothe	er 10 Be	enjamin Pa					
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Baltimore,	ages ant of t: If i		1 ☐ Burial 2 X Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	matory or other place rris & Co	1	25/05	Wost C	hostor	. ра
	nit. F ertme ortar injur		21. Signature of Funeral Service Licens	and the second second second						Chester	
B	Depermonent of the population	٥	Milaine m	Fine?		Name and Address Mitchell-Si 23 S. Was	mith Fu	neral Ho	ome, P	A.	MD 21078
20			232 Part1. Enter the disease, or compl	cations that caused the	death. Do not en	ter the mode of dying	, such as cardia	ac or respiratory a	rrest,	ace, is	Approximate
Į.	Physician		shock, or heart failure. List only or Immediate Cause (Final	_	20.41.0	00=:-10=	~.~ /:1		-15		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a con		OBSTUCT	IVE ZU	NG P	2F113		ZYEMRS
	Examiner										
1		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of):						
V	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events	.							
>,092	an ar	Ex	resulting in death) Last	Due to (or as a con	nsequence of):						
	e lys	Icai		1							
89	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE:								
Вох	eath certifi attending I for use as	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I		Ectopic pregnancy			23d.	Date of delive Month	nry Day Year
0	that the death ed by the atte detached for	sici	1 Yes 2 No	4☐Pregnant at time 9☐Unknown	of death 5[Other (specify)				WOITH	Day 18a
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0.0	requ	etec	HYPERT		1 11100			-			ably 4 Gonaliowii
3ec	: The law cete has t page 2 s	Completed	HIPENI	En / Or				24a. Was	psv	prior to cor	psy findings available inpletion of cause of
of Vital Records,									ormed? 2 ☑ No	death? 1 ☐ Yes	2□ No
V.	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Otho		ath (Check only			
of	Phys this ral dir	٦.	1 Yes 2 No	1 Inpatient 28a. Date of Injury	2 ER/Outpatier 28b. Time o			Home SERes			"
CO	Jing After fune	ion	1 Anatural 5 ☐ Pending	(Month, Day Yea		Work'	at ? ′es 2 □ No	280. Describe	now miluty oc	æurreu	
ISI	Attending r death. ector: After by the funer	ica	3 Suicide 6 Could not be	28e. Place of Injury - A	At home farm str		63 2 110	28f Location	Street and Ni	umber or Rura	l Route Number,
Division	after Dire	Certification:	4 Homicide determined	building, etc. (Sp	pecify)	out, laddy, office			wn, State)		7710010710111007,
	spite nours nerel		29a. Certifier 12 Certifying Physics	sicien: To the best of my	knowledge, deat	h occurred at the time	e, date and plac	e, and due to the	cause(s) and	manner as st	ated.
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exami	ner: On the basis of exar and manner stated.	mination and/or in	vestigation, in my opi	inion, death occ	curred at the time,	date and pla	ce, and due to	the cause(s)
	To the To the Comp	5	29b. Signature and title of certifier	- 1	0	29c. License	number		29d. Date sig	gned (Month,	Day, Year)
			+ Holew N	Occalen	X- R	10 20	F09	6	FEB1	WARY	23 2005
	h		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print)		/ 4	4		- 4
_	2		30. Name and address of person who co	outhor	SICI	mo lo	TT 1	1. N. MI	y' 5	T- 17E	I AIRMU
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature						
	Registr	ar	MAR	0 4 2005	Elater .	1. Spark	20				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For	State of Maryla				lental Hyg	giene)	5 07175
			1 - State Registrar		Certit	icate of De	eath	F	leg. No.	0 0/1/5
P^{μ}	Physici	an	1. Decedent's Name (First, Middle, Last,		VE 8:11	IKE		2. Date of Dea Month	_	3. Time of Death
20	/Media	cal	AUGUSTINA 10 4a. Facility Name (If not institution, give	IT CHUSII				FEB		005 18:51 M
63	Examin	ier	CARROLL HOSP		•	o. City, Town, or Lo WESTA		R	4c. County of	-LROLL
12	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs	. last birthday) I	Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day AUG 5		9. Birthplace (State or Foreign
CO	Director		175 16 8341 10	M 2×F 8-	Yrs.	onths Days	Hours Min.	AUG 5	Year) 1917	Country) PA
#1	pu s		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Locati	00				10d Inside City Limits
3	Marylan f show	ō	MO CARRO		=INKS (10d. Inside City Limits 1 ☐ Yes 2 X No
K	the Mi 28a-f	Director	10e. Street and Number	1		10f. Zip Code			Iog. Citizen of Wh	
5	3a or		4600 SYKESI	lILLE RU	#134		48		1151	A
CHR13	72 hours atter death with the Maryland natural', or Items 23e or 28e-f show Jisul Exar in or Ittual Se ricitified at	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?		Decedent of Hispa s, specify Cuban, I		ecify Yes or No-		- American Indian,
98	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 X No			Specify:	nican, etc.)		White, etc.
5-0036	hours tural',	d by	3 Widowed 4 Divorced	Year or Dates:					Specify:	WHILE
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) p	be filec tal Hyg d othe event,	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle,	Maiden Sumame)	* *
× /		ToE	Joseph Por	CINARI			TONA	-LINIX	2 Ge	1eve
457 Marylan	2 E 8 5		19a. Informant's Name/Relationship (Ty		19b. Mailing A	ddress (Street and	Α.		-	
7 5	l and lealth im 27 her tr		FRANK C. BURK 20a. Method of Disposition	e/Husbard	_ 4600 S	YKESVILL	-	1	INKSBUR	
200	iges 1 of the control of the control		1 XBurial 2 ☐ Cremation 3 ☐ F	lemoval from State	Place of Disposition cometery, cremato	ory or other place)	- 1.	/	20c. Location - Ci	VILLE, MD
Altim	permit. Pa Departmen Important: any injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens			1 Mem F		/2005	,	,
Ba	permit. Departminents Imports any infu		Laky Vi Zu	m brun		ame and Address o				26 MD 21784
			23a. Part1. Enter the disease, or compl	cations that caused the dea						Approximate
	Physician		Immediate Cause (Final	ne cause on each line.	4,			•		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse						Days
10	Examiner		Sequentially list conditions	Chronic	obstruc	tive pu	monar	y di	ease	Years
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p	and and I-trans	Examin	that initiated events resulting in death) Last	Due to (or as a conse	thora	LX				0445
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	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 No	1 Live birth 2 Fet		opic pregnancy her (s <i>pecify)</i>			Month	•
P.O.	at the by th	hys	9 🗆 Unknown	9□ Unknown						
ď.	res that the de signed by the s I be detached t	by	Part II. Other significent conditions cor	tributing to death but not re	sulting in the under	lying cause given in	n Part I.		/	ute to the cause of death?
ord	w require been sign	ted					-	1 1	s 2 □ No 3	Probably 4 Unknown
Sec.	e law has b	Completed						24a. Was a autops	v pric	re autopsy findings available or to completion of cause of
a H	n: Th							perform 1 Yes 2		ath? Yes 2 □ No
<u> </u>	hysicien : The It nis certificate ha I director, page 2	o Be	25. Was case referred to medical examiner? 1 Tyes 2 Tho	lospital:	TER/Output	Othor		(Check only on		
of	ding Phy. h. After this funeral d	-	27. Manne of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?			ence 6 Other	
ion	nding ath. r: Afte e fun	atloi	1 PNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		2 No			
Division of Vital Records,	r Attender death	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h	ome, farm, street,	factory, office		28f. Location (St City or Town		or Rural Route Number,
Ö	itel or rs aft ral Di	O								
	To the Hospitel or All within 24 hours after or To the Funeral Direct completely filled in by	edical	(Uneck only 2 Medical Examil	sician: To the best of my kn	owledge, death oca ation and/or investi	curred at the time, o	date and place, a	and due to the ca	ause(s) and mann	er as stated.
	the the mplet	Med	29b. Signature and title of certifier	and manner stated.		29c. License nu				
	Mi To		A / I	111		1	581	127) 1	Month, Dey, Year)
	h		30. Name and address of person who co	projeted cause of death //te	m 23a) (Type Prin	1000	201)	2/2/0	')
			Wilhur Kuo	295	Stoner	Aue	Suita	307	Westr	ninster, MO
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign				•		
	Reaistr	ar		63 N	a B all) _				

J 1	123		* ·		atment of Health and	-	•					
			State o 1 - Stata Amend Item 18&Unpen Registrar	d Item 23a 27	rificate of Death G84		tas) 05 07176					
	Physici	an	1. Decedent's Name (First, Middle, Last) Tim 6+hu Brown			2. Date of Death Month	Day Year					
,	/Medic		7 im othy Brown 4a. Facility Name (If not institution, give street and nur	nber)	4b. City, Town, or Location of Deat	February	24, 2005 12:11 P M					
	Examili	er	Sinai Hospital	,	Baltimore		N/A					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	9. Birthplace (State or Foreign Country)						
١.	Director		216-06-8793 1⊠M 2□F Usual Residence of Decedent	2 (Yrs.		(Month, Day, Yo	1917 "MD					
21	yland how		10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits					
	8e-f s	ctor	N/A	Balti	more		1 XYes 2 No					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other then "neturel", or items 23a or 28a-f show emportent: if item 27 is marked other then "neturel", or items 23a or 28a-f show emply injury or other treumatic event, it is Medical Exacilier must be retilled at ances.	Funeral Director	5921 The Alameda		10f. Zip Code 21239	10g	. Citizen of What Country?					
	death	nera		dent Ever in U.S. 13.	L Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,					
36	or ite	y Fu	1 Never Married 2 Married 1 Yes	2 No	1 ☐ Yes 2 🗷 No Specify:	Black, White, etc. Specify: Black						
Maryland 21215-0036	ture!	ed by	3 ☐ Widowed 4 ☐ Divorced Year or D	ates:	dent's Usual Occupation	16	b. Kind of Business/Industry					
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and	be fill htal Hy ad oth eveni	Be	17. Father's Wame (First, Middle, Last) Tyrone Brown Sr.			me (First, Middle, Mai						
2	should and Men s marke umatic	2	19a. nformant's Name/Relationship (Type, Print)	19b Maili	Mercul		Tity or Train State Zin Code)					
	and 2 sealth ar n 27 is ner treu	1	Timone Brown Sr.				timere MD 21229					
ore,	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, crei	matony or other place)		c. Location - City or Town, State					
Baltimore,	Pages tment of I tent: if it		`4 □Donation 5 □Other (Specify)	NI.			Baltimore, MD					
Bal	permit. Departrimporte any inju		21. Signature of Funeral Services Licensee Villight C. Ercent Funeral Services 5151 Baltimore National Pike Baltimore									
i,			23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause on e				Approximate Interval Between					
	Physician	e W	Immediate Cause (Final disease or condition resulting in death) Narco	tic intoxicat	ion and cocaine u	ıse	Onset and Death					
	/Medical Examiner		Due to	or as a consequence of):								
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	ecuted ind transii	Examiner	that initiated events c.									
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687	ficate g phys is the		d									
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о В	ies that the death certifica igned by the attending phi be detached for use as th	by Physician/Med		ant at time of death 5	Other (specify)		Month Day Year					
P. 0.	that the	/ Ph	Part II. Other significant conditions contributing to d	eath but not resulting in the u	Inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?					
rds	quires n sign uld be					1 ☐ Yes	2 □ No 3 □ Probably 4 ∰Unknown					
900	aw requir is been si 2 should b	plete				24a. Was an	24b. Were autopsy findings available					
Ä	The late happage	Completed				autopsy performe 1 2 Yes 2						
Vita	icien: certific ector.	Be	25. Was case referred to medical examiner?		Othor	ath (Check only one)						
o	Phys r this eral dir	: To	27. Manner of Death 28a. Date	npatient 2 X ER/Outpatier of Injury 28b. Time o		dome 5 Residence	e 6 □Other (Specify) injury occurred tink					
ion	nding ath. r: Afte e fune	atlor	1 Natural 5 Pending 2 Accident investigation found	05 ^{ay Year)} 12:00 found	a ^M 1 □ Yes 2 X No		Q.A.					
Division of Vital Records,	or Atte	Certification:	3 Suicide 6 Could not be 28e. Place build	of Injury - At home, farm, string, etc. (Specify)		City or Town, S	at and Number or Rural Route Number, State) 3621 Lucille Ave.					
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the		dwe1	_	h occurred at the time, date and place	partimor	e , maryland					
	he Ho in 24 h he Fu pletely	Medical	(Check only 2X Madical Examinar: On the b	asis of examination and/or in ner stated.	vestigation, in my opinion, death occ	urred at the time, date	and place, and due to the cause(s)					
	To t	Σ	29b. Signature and title of certifier	~	29c. License number OCME		. Date signed (Month, Day, Year)					
•			30. Name and address of person who completed cause	the death (team see) To		Fe	ebruary 25, 2005					
			The one remains of person who completed cause	or death (frem 23a) (Type,	111 Penn Stre	eet Balti	more, Maryland 21201					
	Sta		31. Date filed (Month, Day, Year). 32.	egistrar's Signature			- y j					
Е	Regist	ar	MAR 0 4 2005 .5	100 A 100	1842							

			For State Registrar	ricase	State			/ Depa		t of H	ealth a		ental Hy		20	105	07	177
	Physici: /Medic		1. Decedent's Name Mary Adel		t)							F	2. Date of D Month ebrua	eath ry 2	₹,	2005	3. Time 11:15	
	Examin		4a. Facility Name (# Woodside		street and n	ımber)			4b. City,		Location o		ng			ty of Death		
	Funeral Director		5. Social Security No. 231-50-90	29 1	ex □M 2 5 2 F	7. Age (li	7 0	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min. A	8. Date of B (Month D pr 25	9. Birthplace (State or Foreign 1973 4 DC Country)			or Foreign	
	aryland ahow	_	Usual Residence of 10a. State	10b. County				own or Lo									10d. Inside	City Limits
	vith the M or 28a-f	Directo	MD 10e. Street and Nun 7.1.0 Provided					r Sp	10f. Zip							f What Co	untry?	S 2 140
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Brought in Italian 21 is marked other than "natural" or liems 23a or 28a-f ahow any injury or other traumatic event. It a Moulcal Examination and the natified at once.	by Funeral Director	710 Roede: 11. Marital Status 1 Never Marri 3 28 Widowed	ed 2 Married	12. Was Dec Armed F 1 ☐ Yes If Yes, G	orces? 2 Mo ive	r in U.S.	1	Was Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 ▼ No Specify:				cify Yes or N lican, etc.)	United States 14 Race - American In Black, White, etc. Specifical ack			ncan Indian, e, etc.	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow Ta Moolical Exa. iling i wat Du notified at	Completed b		15. Decedent's Edify only highest gra	de completed			6a. Deced (Give life.	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired	ation furing mosi)	t of workin	g	1.		Business/I		
yland 2	ould be filed v Mental Hygie arked other i	To Be Co	17. Father's Name (orris						Į.	Veola	You						
	and 2 sh ealth and n 27 Is m		19a. Informant's Na Hubbard J				7	10 R	oeder	Rd.	#110		Route Numi					
Baltimore,	Pages 1 ment of H ant: If iter			osition Cremation 3 5 Other (Specify					sition (Nam natory or o Valle		θ)	Ма 20	nte r 2 05	-		le, \	Town, State	
Balt	permit. Depart Import any inj	ļ	21. Signal ure of Fu	i El	HOL	Va	10	9	33 Gi	st A	ve.	Silv	ation er Spr	ing	vice	s)		
	Physician /Medical		23a Part I. Enter the shock, or heat Immediate Cause (disease or condition resulting in death)	ne disease, or com nt failure. List only Final n	a. Adu	1t Re	spir	tory					respiratory	arrest,			Approxim Interval B Onset and 24	etween
B	Examiner	er	Sequentially list con	nditions,	b. Chr	o (or as a co	Cong	estiv	re Mes	art l	Failu	re					5	yrs
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rds, P	quires that n signed t	by	Part II. Other signif	icant conditions o			ot resultin	ng in the u	nderlying c	ause give	en in Part I.						the cause of	
Vital Records,	: The law requires that the cate has been signed by the page 2 should be detache	Completed	Canc	er Liver									24a. Wa auto peri 1 Yes	opsy formed?		prior to c death?	topsy finding ompletion of 2 \(\text{No}	s available cause of
of	ding Physician: Th th. : After th's certificate tuneral director, pag	tion: To Be	25. Was case refer examiner? 1 Yes 2 X 27. Manner of Deat 1 XNatural 2 Accident	No	28a. Date (Mo	Inpatient of Injury onth, Day Yo		Outpatier b. Time o		8c. injury Work	at	rsing Hom	(Check only le 5 ☐ Res 8d. Describe	idence			ify)	
Division	al or Attending s efter death. il Director: After id in by the fune	Certification:	3 Suicide 4 Homicide	6 Could not be determined	200. Flat	ce of Injury ding, etc. (3	- At home Specify)	, farm, str	eet, factory	, office		2	8f. Location City or To	(Street a own, Sta	nd Nun le)	nber or Ru	ral Route Nu	mber,
	To the Hospital or within 24 hours efter To the Funeral Director completely filled in b	Medical (29a. Certifier (Check only one)	1⊠XCertifying Ph 2 Medicel Exer	niner: On the	ne best of n basis of ex nner stated	amination	dge, deat and/or in	h occurred vestigation,	at the tim , in my or	ne, date an pinion, dea	d place, ar th occurre	nd due to the d at the time	e cause(s) and r	manner as e, and due	stated. to the cause	(s)
)	To ti withi To ti	×	29b. Signature and	title of certifier	gln P	Belto	~		1		number	86					Day, Year)	
	h		30. Name and addr		completed car	use of deat	h (Item 23	a)(Type.	Print)				C		•			
	Sta Regist		31. Date filed (Mon	th, Day, Year)	32. 2005	Registrar's	Signature	J.	Span	N.								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:50 PM OOHER 2005 /Medical Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death . Salisbury DASTA HOSPICE @ the Maryland Wicomico Lake If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Funeral Days Hours Min. 1 M 200F Director Yrs. 56 216-52-5968 Usual Residence of Decedent 09/12/1948 MD with the Maryland 10a State 10b. County 10c. City, Town or Location Itam 27 is marked other then "naturel", or items 23s or 28s-f show other treumstic event, the Mcdical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No MD Worcester Ocean Pines Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death by Funerai 21811 56 Nottingham Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Commercial Linen Elementary/Secondary (0-12) College (1-4or 5+) District Sales Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Jerry Hahn Gerry Culotta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John William Booher /Husband 56 Nottingham Lane Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Mar * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc.
22. Name and Address of Facility Beltsville, Maryland 2005 21. Signature of Funeral Service Licensee 28800m Kulil Cremation and Funeral Alternatives Baltimore, Maryland 21286 Approximate Interval Between Onset and Death 8717 Green Pastures Drive 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metestatic **Physician** ONE MONII /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ad by the attending physician and detached for use as the burial-transit certificate be axecuted Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signad by the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig , page 2 should b Yes 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No certificate has autopsy performed? 2DANO 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Appatient this 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 50/N/ MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) County M P.O. BX 32. Regetrar's Signature 31. Date filed (Month, Day, Year) MAR 0 4 2005 Eleve Registrar

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	Funeral		5. Social Security Number 6. Sec. 1213–36–1428	7. Age (In yrs.	Yrs.	Months Days	If Under 24 Hr. Hours Min	. (Month, Day,	rear) C	thplace (State or Foreign ountry)			
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	land 11		10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits			
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	with o	<u>=</u>	1934 Sulphur Sprin	ng Road		21227		10		d States			
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	iter d	Š	11. Marital Status 1 Never Married 2 Married	Armed Forces?	13.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Pue	rto Rican, etc.)	Black, Whi				
36	rs af	by F	3 ₩Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White			
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Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "naturel; or items 23s or 28s-f show or other traumatic event. The Medical Examinar must be notified at		William Brophy, J	•									
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Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Country		22	. Name and Addres	s of Facility Hu	ibbard Fun	eral Home	Inc.			
ш_	20729				4	1107 Wilke	ens Aver	nue, Baltin	nore, Mary	rland 21229			
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×	death certific e attending p d for use as	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregn	ancy				22d Data of da	lines			
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οr		Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe how					
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	spit hours nere		29a. Certifier 1 Certifying Phys	sicien: To the best of my knowner: On the basis of examina	owledge, death	occurred at the tim	e, date and plac	e, and due to the cau	se(s) and manner as	s stated.			
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	CA		31. Date filed from Dan, Year)	36 Registrar's Sign	ature	Jurace J	1	ouic 4	o, valu	2/201.			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:00 P M Patricia Ann Brown February 23, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year Sept 8, 19 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 21XF 35 Director 212-80-4167 1969 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 ie marked other than "natural", or Iteme 23a or 28a-f ehow traumatic event, the Medical Exactinar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland Baltimore Owings Mills 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21117 United States 26 Garrison Ridge Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. education 12 school bus driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be finand H Be John W. Henley, Sr. Catherine Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Dale Henley - brother 1830 Colmar Road, Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ö 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: if any injury or once. Loudon Park Cemetery 2/26/2005 Baltimore, Maryland ^¹ 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, hr omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metastatic dher to longin Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNKnown phunar mont Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. signed to Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Hospital or Attending Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after a To the Funeral Direct 4 | Homicide pc Pertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)58303 February 24 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) So Red toucher with 217004 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 4 2005 Registrar

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200. Method of Disposition Date 200. Location - City or Town Committee Cedar Hill Cem 03/02/05 Baltimore,	21122
169 Riviera Drive, Pasadena, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final resulting in death) 1	or Town, State
169 Riviera Drive, Pasadena, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final resulting in death) 1	re, MD
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The state of the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (check only one) We state of the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (check only one) We state of the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (check only one) 29b. Signatore and title of certifier 29c. License number 29d. Pate signed (Month, Date of the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (check only one) 29b. Signatore and title of certifier 29c. License number 29d. Pate signed (Month, Date of the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (check only one) 29b. Signatore and title of certifier 29c. License number 29d. Pate signed (Month, Date of the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (check only one)	
29c. License number 29d. Pate signed (Month, Da	as stated. Jue to the cause(s)
Juna The James Mas Deg 7-28/1 1-128/25	onth. Day. Year)
	-
30. Name and address of person who completed cause of death (Item 23a) (Type Print)	
Jonathan Former MD Doo 23811 I [28] 05 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Former MD 1490B 5, Crain 304 Glan Burnie MD 2-1	2-1061
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

hysician	1	State Amend Item 28f Registrer 1. Decedent's Name (First, Middle,				Cei	uncate	9 01 1	Dealli	2.	Date of Dea	ath	-	<i>J</i>	3. Time of	Death
		-	xter							F	Month ebrua	rv 26	5.	2005	03:21	
/Medical Examiner	4	a. Facility Name (If not institution,	give street	and number					r Location of				County o		00,12	
Addition.		Crain Highway at	t Mat	towoma	n-Bea	ntown	Wa	.1doı	cf				Ch	arle	S	
ineral	5	5. Social Security Number 6	6. Sex 1 ☐ M 2		ge (In yrs. I	ast birthday)	If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birt (Month, Da	y, Year)		9. Birthpi Coun	ace (State o	or Foreig
rector		77-74-4526 Usual Residence of Decedent	1 U IVI 2		, ,	Yrs.				D	ec. 1	6,19	953	Was	h.,	DC
Mo to		10a. State 10b. County			10c. City	, Town or Lo	ecation							11	Od. Inside C	ity Limit
to it		MD Prince	Geo	rges	Dis	trict	Hei	gh t						i	X Yes	2 🗌 N
Important: If Item 27 is marked other then "naturel", or Itame 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once. To Be Completed by Funeral Director	. 1	10e. Street and Number		-	1		10f. Zip					10g. Citize	en of WI	hat Coun	try?	
23a c	6	036 Parkland	Cour	t			207	47				USA	A			
r Itame 23a	1	11. Marital Status	Ar	as Deceden med Forces	?		Was Decede	ent of H	ispanic Origi In, Mexican,	n? (Specif Puerto Ric	y Yes or No an, etc.)	- 14		- Americ White,	an Indian,	
ar, or i		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	if '	Yes 2 2 Yes, Give			1 ☐ Yes 2	No 🍱	Specify:				Specity:	B1a	ck	
ed t	: -	15. Decedent's		ear or Dates:		16a Dece	dent's Usua	I Occup	ation		antain	16b. Kin	d of Bus	iness/Inc	lustr.	
t, the Medical I	<u>.</u> -	(Specify only highest Elementary/Secondary (0-12)	grade com	pleted)	· F · \	(Give life.	kind of worl	k done d e retired	during most o	of working		100.10	u 01 Dus	111033/1110	lustry	
mo.		12	4	ollege (1-4or	3+)	F	legis	ter	edNur	se		Pr	iva	ate		
event Be (1	17. Father's Name (First, Middle, La	ast)						18. Mother	s Name (F	irst, Middle,	Maiden S	Sumame)		
To atic		Grover Baxte	r, S	r.					Hel	len S	Galli	е				
E W		19a. Informant's Name/Relationship		•					and Number							
thert	_	Heleene Beynu	m/Da	ughte		5036 lace of Dispo			d Ct.	, Date		ct H	_			207
# 6 # 6	-	1 Burial 2 ☐ Cremation 3		al from State	1 0	emetery, crei	matory or ot	her plac					ation - C	ity or 10	wn, State	
njury	1	4 □ Donation 5 □ Other (Special21. Signature of Pureral Service		-/	Re	surre	ctio	n d Addres	3	-8-2	005	C11	nto	n.		_
any ir	1	21. Signature of Great Angelve	Con	1		ĺ	722 1	Nor	ss of Facility th Ca	pito	I'st:	reet	, N		ome ash.,	DC
	+	23a. Part1. Enter the disease, or or	complication	ns that cause	d the death	n. Do not ent	er the mode	of dyin	g, such as ca	ardiac or re	spiratory ar	rrest.		21	0001 Approximat	Θ
ician		shock, or heart failure. List or Immediate Cause (Final	nly one dat	use on each	line.	.0,		-	1.0)					Interval Bet Onset and I	
dical		disease or condition resulting in death)	Pd	Due to (or a	s a consed	ence of):	100	Xu.	rues							
iner			,	, , , , , ,	,		,									
iner in	1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	J	Due to (or a	s a consequ	uence of).										
ial-transit Examiner		Cause (Disease or injury that initiated events resulting in death) Last	c	Dua to /or o												
				Due to (or a	s a consequ	Jence oi):										
			d													
for use as		IF FEMALE: 23b. Was decedent pregnant		yes, outcom								23	3d. Date	of delive	rv	
ia is		in the past 12 months? 1 □ Yes 2 BNo	4	Live birth Pregnant]Ectopic pre] Other <i>(spe</i>						Mont		*	/ear
detached		9 Unknown	91	Unknown												
be del	F	Part II. Other significant condition	is contribut	ting to death	but not resu	ulting in the u	nderlying ca	use give	en in Part I.			4			e cause of d	
	-									,	101	∕es 2 <mark>/⊠</mark>	No 3	Proba	ably 4 🗆 l	Jnknow
ted t	1										24a. Was autop	sy	24b. W	ere autorior to con	sy findings	availabl
2 should	-											rmed? 2 ☐ No	de	ath?	2□ No	
2 should	-	25. Was case referred to medical examiner?	Hospit	al:				Oth			heck only o			-		
2 should	3 2			1 🗀 Inpat		ER/Outpatier 28b. Time o			4 Nurs		5 Resid			(Specify	SCENE	-
2 should	2 2	1XXYes 2 □ No 27. Manner of Death	1		ay Year)	Injury	5 M	Bc. Injun Worl		h.	cecuse	l PS	enge	rotte	cupting	Lt
luneral director, page 2 should	2 2	27. Manner of Death 1 □Natural 5 □ Pending	28	a. Date of In (Month, D	-05	2.1)			-	Location (5	Street and	Number	or Rurai	Route of m	SId ber
Iuneral director, page 2 should	2 2	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	ation Z	Z-Z6	njury - At ho	me, farm, sti	eet, factory,	, office							12 11 117	
Inneral director, page 2 should director, page 2 should director, page 2 should don; To Be Completed	2 2	27. Manner of Death 1 □Natural 5 □ Pending 2 ♣Accident investiga	ation 28	Z-Z6	-	0	eet, factory,	, office			City or Tou	vn, State)	Cra	cr Hi	Sylver	us
Atter this certificate has been a funeral director, page 2 should lion; To Be Completed		27. Manner of Death 1	ation 28 ati	2-Z(e) le. Place of lubuilding, e	njury - At ho	viglu wiedge deat	n occurred	the tim	ne, date and	place, and	City or Tow	RF cause(s) a	nd man	Chd	Tyles C	6.
Atter this certificate has been a funeral director, page 2 should lion; To Be Completed		27. Manner of Death 1	ation 28 28 28 28 28 28 28 28 28 28 28 28 28	2-Z(e) le. Place of lubuilding, e	njury - At ho etc. (Specify at of my kno of examinal	viglu wiedge deat	h occurred a	the tin	ne, date and pinion, death	place, and	City or Tow ALDO due to the eat the time,	cause(s) a date and p	and mani place, an	ner as stand due to	ated. the cause(s	6.
inneral director, page 2 should		27. Manner of Death 1	ation 28 28 28 28 28 28 28 28 28 28 28 28 28	2-26 le. Place of Inbuilding, e	njury - At ho etc. (Specify at of my kno of examinal	viglu wiedge deat	h occurred a	the tim in my o	pinion, death —————— e number	place, and	City or Tow ALDO due to the eat the time,	cause(s) a date and p	and mani place, an	ner as stand due to	ated. the cause(s	6.
Inneral director, page 2 should director, page 2 should director, page 2 should don; To Be Completed		27. Manner of Death 1	ation of be and 28 physician examiner: 0 a	2 - Z (e) le. Place of Ir building, e 1: To the bes on the basis and manner s	njury - At ho etc. (Specify t of my kno- of examinal stated.	wledge, deat	n occurred a vestigation,	the tin	pinion, death —————— e number	place, and	City or Tow ALDO due to the eat the time,	cause(s) a date and p	and mani place, an	ner as stand due to	ated. the cause(s	6.
2 should		27. Manner of Death 1	ation of be and 28 physician examiner: 0 a	2 - Z (e) le. Place of Ir building, e 1: To the bes on the basis and manner s	njury - At ho etc. (Specify t of my kno- of examinal stated.	wledge, deat	h occurred evestigation, 29c.	the time in my of the License OCM	pinion, death —————— e number	place, and occurred	due to the at the time,	cause(s) a date and p 29d. Date	and maniplace, and signed uary	ner as strand due to	ated. the cause(s)

DHMH 16 Rev 6/95

Registrar

		•	For State	State of Maryland	Department of Health ar Certificate of Death		2005 07101
			Registrar 1. Decedent's Name (First, Middle, Las	st)	Octunicate of Death	Reg. N	3. Time of Death
	Physicia		ALICIE	CREQUI	3		3 2005 10:26 M
į.	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of		4c. County of Death
	:		NORTH WEST	- HOSPITAL	Rendallsto	wh	BALTIHORE
	Funeral		5. Social Security Number 6. S. 0 9.3 - 28 - 4212	ex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Months Days Hours	Min. (Month, Day, Yea	Birtholace (State or Foreign
	Director	-	Usual Residence of Decedent	70 60	115.	DEPT. 30, 1	936 NEW YORK
	yland		10a. State 10b. County	10c. City, T	own or Location		10d. Inside City Limits
	Ba-f e	ctor	MARYLAND SAL	TIMORE	RANDALL	5 TOWN	1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number		10f. Zip Code	1(2)	Citizen of What Country?
	72 hours after death with the Maryland natural; or Itams 23a or 28a-f ehow ileal Examinat neut be notified at	Funeral Director	8 60 8 10R/A	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin	n2 (Specify Vec or No.	USA. 14. Race - American Indian,
(0	r Itam	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🗷 No	If Yes, specify Cuban, Mexican,	Puerto Rican, etc.)	Black, White, etc.
030	ral', o	Þ	3√ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2,2,No Specify:		Specify: BLACK
21215-0036	30	Completed	15. Decedent's Ed (Specify only highest gra	ducation 1 de completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of	of working 16b.	. Kind of Business/Industry
121	withir ane. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	TELLER		BANK
	Hyge Hyge	Be Co	17. Father's Name (First, Middle, Last)			s Name (First, Middle, Maid	
Maryland	9 6 5 0	To B	HERMAN	WILL	IAMS Ras	SETEA	FOREMAN
lary	and N ls ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number	or Rural Route Number, City	y or Town, State, Zip Code)
	s 1 and 2 should f Health and Men itam 27 Is marke other traumatic	1 12	LESLIE DAVIS	(DAUGHTER)	8608 BRAMBLE.	LANE, RANDA	45ROWN MD. 21133
Baltimore,	o = 0		20a. Method of Disposition [†] Burial 2 ☐ Cremation 3 ☐	cem	e of Disposition (Name of etery, crematory or other place)		Location - City or Town, State
Him	permit. Pag Department Important: I any injury o	1	4 ☐ Donation 5 ☐ Other (Specify21. Signature of Funeral Service Licer) M	HOPE CEMETERY O	3-09-05 HA	TINGS ON HUDSON, NY
Ba	permit. I Departm Importar any inju		The hold	11.4 Illian	JOSEPH H	TON AVE BY	R. FUNERAL HOME ALTO, MD. 21217
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused the death. I	Do not enter the mode of dying, such as ca	ardiac or respiratory arrest,	Approximate
	Physician		Immediate Cause (Final disease or condition		TO HIC CORONARY	ANTERLY D	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequen	ice of):		
Н	Examiner	_	Sequentially list conditions, if any, leading to immediate	0.	- VASCULAR AC	UDENTI	
	bed nsit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	Ce 01):		
Ţ,	al-trai	Examin	that initiated events resulting in death) Last	C. Due to (or as a consequen	ce of):		
68760,	icate be executed physician and s the burial-transit	dlcal	(d	<u> </u>		
	ntifical ng phy as th		IF FEMALE:				
Вох	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	ath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
0.	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of deati 9□ Unknown	h 5 Other (specify)		World Day real
<u>α</u>	that ti		Part II. Other significant conditions of	ontributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Records,	quires n sign ald be	d by				1 ☐ Yes	2 No 3 Probably 4 Joknown
CO	aw requ s been 2 shouk	Completed				24a. Was an	24b. Were autopsy findings available
R	The law cate has page 2	mo				— autopsy performed∑ 1 ☐ Yes 2 🔀 I	
Vital	ician: T certificat rector, pa	Be C	25. Was case referred to medical examiner?			f Death (Check only one)	
of V	shys this aldi	스	1 ☐ Yes 2 ☐ No			ing Home 5 Residence	
	Jing After fune	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	(Month, Day Year)	b. Time of linjury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
Division	or Attanding Ifter death. Diractor: After in by the fune	fical	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of Injury - At home			and Number or Rural Route Number,
ρį	al or safter	Certification:	4 Homicide	building, etc. (Specify)		City or Town, Sta	ate)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying Ph	ysicien: To the best of my knowle	dge, death occurred at the time, date and and and/or investigation, in my opinion, death	place, and due to the cause	(s) and manner as stated.
	To tha H within 24 To the F complete	Medical	one)	and manner stated.			
	To To	4	29b. Signature and title of certifier	N. 0	29c. License number		Date signed (Month, Day, Year)
	0		20 Name and addison	pompleted source of death (tham 2)	000 560	150 110	3 2005
	Ψ	7	Source Plateu	M.D. 540	"Old" Court Ro	130 MAHimo	N. M. 21133
	Sta	ate :	31. Date file (Month, Day, Year)	32. Registrar's Signatur	Land of		
	Regist	rar	MAR U 4-ZUUS	Beserry Dr A			

EDWAR 05-15	D LYTELI 16	L C	OE JR unpend/Please	Type or Prin	t in Black	Indelible lak	2 Ensure All	Copies Ar	e Legible.	
			_ State	State of Ma		epartment of F Certificate of			200	07105
	0.		 Registrar Decedent's Name (First, Middle, Las 	t)		Jeruncale or		Reg. 2. Date of Death		3. Time of Death
	Physici /Medio		EDWARD LYT	FELL CO	E JR		F	EBRUARY 2	28, 2005	5:20a M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	T	4c. County of Death	1
7	Funeral		5. Social Security Number 6. So	7. Age	(In yrs. last birth	If Under 1 Year				place (State or Foreign
X	Director		219.74.8378 1	⊠ M 2□F	48 v	rs.	Hours Mill.	B. Date of Birth (Month, Day, Ye	957	MD
-1	Aaryland f show	or	10a. State 10b. County MD Baltin	nore	10c. City, Town	0.4 - 11 -				10d. Inside City Limits 1 ☐ Yes 2 ②No
	after death with the Maryla or Hems 23a or 28a-f shor	Funeral Director	10e. Street and Number 401 Sihler D			10f. Zip Code	-1117	10g.	Citizen of What Cou	untry?
	ier death w Items 23a ner must b	nerai	11. Marital Status	12. Was Decedent E		13. Was Decedent of H		ify Yes or No-	14. Race - Amer	
036	be filed within 72 hours after death with the Maryland thygiene. Hygiene. d other than "natural" or tems 23a or 28a-f show event, the Medical Evantral must be rediffed at	d by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🛱 No		ican, etc.)	Specify: B	ack
21215-0036	within 72 hours ene. than "natural", he Wedical Ex	Completed by	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	de completed) College (1-4or 5-		Decedent's Usual Occup Give kind of work done life. DO NOT use retired	during most of working d)	7	. Kind of Business/l	
121	be filed within tal Hygiene.		12th grade 17. Father's Name (First, Middle, Last)	2 years		Branch	Manag 18. Mother's Name			Boilernment
lan(To Be		= iSr.			Audre			
Marvland	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (7	2 - 0		Mailing Address (Street	and Number or Rural	Houte Number, Ci	11 1	
	Heal her		Karen B. Freem 20a. Method of Disposition	nan/Wif	20b. Place of	Disposition (Name of	Caks Ira		Leastion - City or T	MD 2117
0	Pages nent of h ant: If ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify			r, crematory or other place	D-7 5	7.05 I		re MD
Baltimore.	permit. Pages: Department of H Important: If ite any Injury or ot		21. Signature of Funeral Service Licen	see		22 Name and Addre	ss of Eacility	uneral Se		. HD 21229
	. 40244		23a. Part1. Enter the disease, or comp	olications that caused	the death. Do no				Ke Balto	Approximate Interval Between
	Pnysician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	Asphyxia						Onset and Death
	/Medical- Examiner	П	resulting in death)	Due to (or as a	consequence of):				
	THE S.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence o):				
	ecuted and -transit	kaminer	that initiated events resulting in death) Last	C. Due to (or se s	a consequence of	η.				
68760.	Attending Physician: The law requires that the death certificate be exect refacth. The death contilicate has been signed by the attending physician an exter. After this certificate has been signed by the defactor and the funeral director, page 2 should be detached for use as the burial-in	cai Ex		d	2 3311334201133 31	·/·				
.89	leath certificate be attending physic ifor use as the b	Physician/Medical	IF FEMALE:							
P.O. Box	eath ce attend	cian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1	2 Fetal death	3 ☐Ectopic pregnancy	/		23d. Date of delive Month	rery Day Year
O.	that the ded by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	res tha signed be de	by	Part II. Other significant conditions of	ontributing to death bu	it not resulting in	the underlying cause giv	en in Part I.		co use contribute to	
Sorc	w requir been si should	eted						1 ☐ Yes 24a. Was an		bably 4 DUnknown opsy findings available
Vital Records.	The lay te has	Completed						autopsy performed	prior to co	ompletion of cause of
ital	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?	44			26. Place of Death (-	10 723.00	2310
of \	Physic rthis c	. To	1 X Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatier		patient 3 DOA Oth	4 Nursing Home	e 5 Residence	6 W ther (Special	
ion	Attending I death. ctor: After y the funer	atior	1 ☐ Natural 5 ☐ Pending 2 ⚠ Accident investigation	Find Month, Day 2/28/20		me of 28c. Injur Wor 200 A ^M 1 □	Yes 2X No ac	d Describe how in elieved e ctivity	engaged 11	l ^b attberotic
) Division of	al or Attensater deat	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc		n, street, factory, office	28	of. Location (Street City or Town, St Blvd Arbu	t and Number of Run tate) 5648 S Itus MD	al Route Number Southwestern
20	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best o	f my knowledge, examination and	death occurred at the tir /or investigation, in my o	me, date and place, an	d due to the cause	e(s) and manner as	stated. to the cause(s)
	Vithin To the	Me	29b. Signature and title of certifier			29c. Licens	e number		Date signed (Month,	
			I hade Il	1 X / X	nn	OCI	ME ————————————————————————————————————	FE:	BRUARY 28	, 2005
			30. Name and address of person who	completed caused de	eath (Item 23a) (1	ype, Print) 111 Pei	nn Street	Baltimon	ce, Maryla	and 21201
	Sta Regist	ate	31. Date filed (Month A.P. e.) 4	2005 32. Figistra	r's Signature	South .				

DHMH 17 Rev 1/2001

ORIGINAL

3	20		Stata Amend Item 18	State of Maryla Unpend Item	nd / Depa 23a , pt	rtment of 1	lealth and l a-f per i Death 3-2	Mental Hygier ne G841 3-05 tas	2005	07186
	Physicia		1. Decedent's Name (First, Middle, Last)	Franklin Alc			-0	2. Date of Death	Dav Year	3. Time of Death
,	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	CA	4b. City/Town, or	r Location of Death		28, 2005 4c. County of Death	11:06 A M
	Examili	CI	Maryland General H			Baltimo			NIA	
	Funeral Director		5 Social Security Number 2/7 - 84 - 7027 1X	M 2 F	yast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yei MARCH 19	ar) Cou	place (State or Foreign ntry)
)	and w		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	cation				10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumatic svent, the Medical Examinar must be notified at	Director	MARYLAND N	/A	My, Town or Lo	.6)	TIMOR	E CIT	1/	1. Yes 2 □ No
	3a or 2	ai Dire	10e. Street and Number $16(3i D)V/s$	10 NST 15	FLOOR	10f. Zip Code	2121	7	citizen of What Cou	ntry?
	ems 2	Funerai		12. Was Decedent Ever in Armed Forces?	U.S. 13.	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-	14. Race - Ameri Black, White,	
5-0036	ours afte ral', or It Examin	by	1, Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:		l□Yes 2⊠No	Specify:	,,	Specify: B	ACK
15-0	"natu	Completed	15. Decedent's Edu (Specify only highest grad		(Give	lent's Usual Occup kind of work done o OO NOT use retired	durina most of wor	king 16b	. Kind of Business/In	dustry
2121	withir iene. than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		EMPLO	′		NIA	
	be filed tal Hygid d other svent, II	BeC	17. Father's Name (First, Middle, Last)		1 01100			ne (First, Middle, Maio	den Sumame)	
ylaı	2 should be filed within and Mental Hygiene. is marked other than eumatic svent, the Me	To	FRANKLIN	A. CAN	JTY.	SR.		HANIE		
Maryland	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (Ty	` /	1 4 .	Car 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4		ral Route Number, Cit		
	Health tem 27 other tr		STEPHANIE MADI 20a. Method of Disposition		Place of Dispo	sition (Name of		Date SAL	Location - City or To	
E	Pages nent of int: If it	Hi	1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other place		05-05 U	200D1 AM	WMD.
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens		, 22	. Name and Addres	ss of Facility	ROWNJA	FUNER	AL HOME 0.21217
	80589	1 1	1 which	V. Willian					BALTO. M.	
B	Pnysician	8 1	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line. Narcotic In		,	ig, such as cardiac	or respiratory afrest,	1	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conse		TOIL				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):					
	be executed ician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, (Disease of India) that initiated events resulting in death) Last							
8760,	icate be ex physician s the burial	aiE		Due to (or as a conse	equence or):					
9	g physias the	edicai		1						
Вох	eath certific attending p for use as	an/M	23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,		23d. Date of deliv	
P.O. E	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown		Other (specify)			Month	Day Year
	res that igned b	by Pt	Part II. Other significant conditions con				en in Part I.	23e. Did tobaco	co use contribute to t	he cause of death?
ord	w require been sign	ted	Atherosclerotic Ca	rdiovascular	Disease	?		1 🗆 Yes	2 No 3 Prob	pably 4 Munknown
Records,	e law has b	Completed						24a. Was an autopsy performed	prior to co	ppsy findings available impletion of cause of
	iiclen: The lav certificate has rector, page 2		25. Was case referred to medical				00 Plans of Pass	1 Yes 2□	No 1 Yes	2 No
>	ysiclen: is certific director,	To Be	axaminar?	Hospital: 1 ☐ Inpatient 2[XER/Outpatien	t 3 DOA Oth		th (Check only one) ome 5 🗆 Residence	6 □Other (Specif	(v)
Division of Vital	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 Pending	Pound 28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun		28d. Describe how in		unk
Sio	ttsndi Jeath. tor: A the fu	icati	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide	2-28-05	10:15	A	Yes 2 No	Of Landin /Charle		12
Div	after Direct	Certification;	4 Homicide	28e. Place of Injury - At building, etc. (Specification)	cify)	вет, тастогу, опісе		28f. Location (Street City or Town, St Baltimore,	ate) 1631 Di	vision St.
	To the Hospitel or Attending Physiclen: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kr ner: On the basis of examir and manner stated.	nowledge, death	n occurred at the tin vestigation, in my o	ne, date and place	and due to the cause	e(s) and manner as s	stated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Month,	Day, Year)
			I king his,	mid		OC	ME	Mar	ch 1, 200	5
			30. Name and address of person who co		em 23a) (Type,		C			
	Sta	ate.	31. Date filed (Month, Day, Year)	, M 2. Registrar's Sign	nature 🎍	III Pe	nn Stree	L Daltimo:	re, Maryla	1110 Z1ZUI
	Regist		MAP 0 4 2005		1004	E .				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) **Physician** ROBERT LEWIS CURTIS FEB 12:56P M 26 2005 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 24 Hrs. 8. Date of Birth (Month, Pay, Nov. 18, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) ^{Year)}953 **Funeral** Days Hours XXM 2□F 51 Arkańsas 558-92-1602 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits rei', or items 23a or 28e-f shov Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9824 Gerogia Ave., #203 20902 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1971-96 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 K Divorced neturel 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Personnel Manager U.S. Military Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 le marked othe any injury or other traumatic event sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Curtis Wrilma Warren Wright ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kanneth J. Kasprzak / Partner 9824 Georgia Ave. #203; Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 3/03/05 Beltsville, MD 21. Signature of Funeral Service Oceansee 22. Name and Address of Facility Rapp Funeral and Cremation Services Tuber Toluncum M0382 933 Gist Ave., Silver Spring 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final Priysician MULTIPLE ORGAN FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MENINGITIS Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumuence of Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death P.O. I 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à HIV INFECTION, AIDS, 1 Yes 2 No 3 Probably 4 Unknown Completed DISSEMINATED INTRAVASCULAR COAGULOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 XNo 1 Yes 2 🗆 No 1 Tes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Impatient 2 ER/Outpatient 3□ DOA this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Diractor 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16746 (OR) 30. Name and address of person who completed cause of death (Item 23) (Ty e, Print) NATIONAL NAVAL MEDIC L CENTER LEE W. VANCE LCDR MC USNR 8901 WISCONSIN AVE BETHESDA MD 31. Date filed (Month, Day, Year) 32. Register's Signature State MAR 0 4 2005 Registrar

		I.	1 - For State Registrar	State of Maryl		artment of rtificate of			piene 005	07188
	Dhusisi		1. Decedent's Name (First, Middle, I	Last)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medic		Mary Elizal	beth Cunnir	gham			Februar		1.4
	Examin		4a. Facility Name (If not institution, g	rive street and number)		4b. City, Town,	or Location of Deat	h	4c. County of De	
			Asbury Methodis				hersburg		Montg	gomery
	Funeral		·	. Sex 7. Age (In y	rs. last birthday) Yrs.	Months Day	r If Under 24 Hrs s Hours Min.	8. Date of Birth (Month, Day Feb. 26	Year) 9. Bi	rthplace (State or Foreign country)
ш	Director		234-05-8582 Usual Residence of Decedent	- 11 0,	113.			Feb. 26	,1916 Wes	st Virginia
	/land		10a. State 10b. County	10c.	City, Town or Lo	ocation	-			10d. Inside City Limits
	Man	ξ	Maryland Prince	George's		Greenb	elt			XXYes 2 □ No
	r 28g	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	country?
	th with	a D	37-L Ridge Rd	•		20	770		United	States
	dea	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No-	14. Race - Am Black, Wh	
36	or it	y Fu	1 Never Married 2 X Married	1 □Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		1 ☐ Yes 🎎 XN			Specify:	White
00	ural	d b	3 Widowed 4 Divorced	Year or Dates:						
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Madical Examinat must be natified at	Completed by Funeral Director	15. Decedent's (Specify only highest of	grade completed)	(Give	dent's Usual Occi kind of work don DO NOT use retii	e during most of wo	rking	16b. Kind of Busines	s/Industry
112	with iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		Operator	,			
	e filec otha vant,	e e	17. Father's Name (First, Middle, La	st)	1			me (First, Middle,	Maiden Sumame)	
Maryland	uld by Wenta Menta Irkad Itic e	To B	Stephen Mon	roe Smith			Maude	. My	rtle	Mixer
lar)	2 sho and I is ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Stree	et and Number or Ri	ural Route Number	r, City or Town, State,	Zip Code)
	and ealth m 27		Michael D. Cunn				Rd., Gre		MD 20770	
ore	Jes 1 of H if ital		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	CD	cemetery, cre	osition (Name of matory or other pi	(ace)	Date 28/05	20c. Location - City o	r Town, State
Baltimore,	tant:		`4 Donation 5 ☐ Other (Spe		of the	ervices Health S	ciences		Bethesda,	MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at Once.		21. Signature of Funeral Service Lic	/	6382 R	2. Name and Add app Fune	ral and C	remation	Services	0010
			23a. Part1. Enter the disease, or co	emplications that caused the d			Ave., Sil			0910 Approximate
	Physician		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each line.	1.)	+ 1.			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a con	sequence of):	- near	f faile	av C		6 mg.
	Examiner		Sequentially list conditions	b						
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con-	sequence of):					
/	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the bunal-transit	хап	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):					
8760,	sician buris	lical E								
9	ificate g phy: as the	edic		d						
Вох	n cert andin use	m/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		7			23d. Date of de	alivery
	res that the death certifica igned by the attending pt be detached for use as t	Physician/Med	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4 Pregnant at time		Ectopic pregnan Other (specify)			Month	Day Year
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S	signer d be d	by	Part II. Other significant conditions	s contributing to death but not	resulting in the u	nderlying cause g	given in Part I.	23e. Did to		to the cause of death?
Records,	w requir been si should	Completed by	dementa					•		robably 4 □Unknown
3ec	has h	mpi						24a. Was a autops perfor	sv prior to	utopsy findings available completion of cause of
alF	T ate			1				1 Ves	2 No 1 Ye	s 2□No
Vital	Physician: this certific ral director,	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				ath (Check only or		
of	Phys r this sral di	To :	27. Manner of Death	28a. Date of Injury (Month, Day Yea		IL 3U DOA	4 D Nursing F		ence 6 Other (Sp	ecify)
ion	Attanding r death. actor; After by the funer	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		r) Injury		ork? ⊒Yes 2.⊒No		, , ,	
Division	Attar ar dea actor by the	ifica	3 Suicide 6 Could not	ad 280. Place of Injury - A	t home, farm, st	reet, factory, office	9	28f. Location (S	treet and Number or F	Tural Route Number,
Ö	rs afte af Dire ed in b	Certification:	4 - Homeos	building, etc. (Sp	өспу)			City or Town	n, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After thi completely filled in by the funeral	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of my taminer: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occu	a, and due to the curred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To t To ti	Σ	29b. Signature and title of certifier	11. 11 -1		29c. Lice	nse number	2	9d. Date signed (Mor	
	/		they 16	Milwele	nis	1	19294	1	February o	26,2005
	h		30. Name and address of person wh	~	Item 23a) (Type,	Print)	1 u	/	February of Md. 2087	^
			31. Date fled (Month, Day, Year)	32. Registras S	cri-ell	1 - 1	Ga: thar	say	md. 20 F7	7
	Sta Regista		MAR 0	4 2005 Desa	in the	poste	,			

			1 - For State Registrar	State of	Marylar	-	artment of F rtificate of		nd Me	_	jiene	15	07100
	Physici /Medic		1. Decedent's Name (First, Middle, La Josephine L. Cl	•						2. Date of Dea Month 03/03	/2005	Year	3 Time of Death 6:20P M
	Examin		4a. Facility Name (If not institution, giv		per)		4b. City, Town, o	r Location of	Death		4c. County	of Death	
			124 W. Franklir									N/	
	Funeral Director		217-07-6239	ex	. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 04/12	7 1920	9. Birthi Coul Mar	place (State or Foreign ntry) yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Mary	ţō	Maryland N/	1	Ba	ltimo	re						1XYes 2□No
	death with the Marylan ms 23a or 28e-f show	Directo	10e. Street and Number	1	Du	I CIMO.	10f. Zip Code			1	l0g. Citizen of \	What Cou	ntry?
	th with		124 W. Franklir	Stree	t Ant	#208	2120	1			United	1 S+	ates
	s after deal or items	Funeral	11. Marital Status	12 Mac Doggd	ant Ever in II	I.S. 13.	Was Decedent of H	lispanic Orig	in? (Spec	cify Yes or No-	14. Rac	e - Americk, White,	can Indian,
36	or it	by Fu	1 □ Never Married 2 □ Married	Armed Ford 1 Tes 2 If Yes, Give	•		1 ☐ Yes 2 No	Specify:		, 0.0.,	Specify	·	
Ö	n 72 hours after death with the Maryland "naturel", or items 23a or 28e-f show witcel Excentine trust be notified at		3 X Widowed 4 □ Divorced 15. Decedent's E	Year or Dat	es:	160 Door	dent's Usual Occur	ation				Wh.	ite
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212	d within giene. rr than "	Completed	Elementary/Secondary (0-12)	College (1-4	10 <i>F</i> 5+)	Home	maker			Ì	Domes	stic	
Maryland 21215-0036	be filed stal Hygid of other event, il	BeC	17. Father's Name (First, Middle, Last,)				18. Mother	's Name	(First, Middle,	Maiden Suman	1e)	
<u>ylai</u>			Ignatius Dombro	owski				Mary	Nia	ziolek			
a	2 sho and Is ma		19a. Informant's Name/Relationship (1	ng Address (Street						
	s t and 2 should f Health and Mer Item 27 is marke other traumatic		Stella D. Kardi	an -Si		7278	Conley	Stre			ore, M		
Baltimore,	00		1 Burial 2 Cremation 3				sition (Name of natory or other place		3/07	7/05		•	
듶		1	* 4 □ Donation 5 □ Other (Specification of Funeral Service Light)		Sa		Heart o				Baltin	ore	, Maryland
Ba	permit. Departn Imports eny inju	0 12	4 x 1 /	mil.		D	avid J.	Webe	r Fi	uneral	Homes	P.	A. , MD 21231
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	Examiner		Cognantially list conditions	b	athe	rosde	rusis						yeus
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	ecute and trans	Examine	that initiated events resulting in death) Last	c	r as a conseq	ulopoo of):							
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687	ate hy:	ledicai		d									
Box (eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23d. Dat	e of delive	ery
	death e atte	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No	4 ☐ Pregnar	h 2∏Feta nt at time of d]Ectopic pregnanc _]] Other (s <i>pecify)</i>	<u></u>			Mo	nth	Day Year
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Ś	The law requires that the te has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of	ontributing to dea	th but not res	sulting in the u	nderlying cause giv	en in Part I.		1	bacco use conti es 2 □ No	ribute to th	ne cause of death? pably 4 Unknown
Record	w requir been si should I	ompleted								24a. Was a	n 24h \	Nora auto	psy findings available
Re	The lar	duuc					·			autops	ned?	prior to co death?	mpletion of cause of
Vital		Ö	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes 2 (Check only on		Yes	2 No
<u>></u>	S D	O B	examiner? 1 Yes 2 No	Hospital:	patient 2	ER/Outpatien	t 3 DOA Oth				ence 6 Oth	er <i>(Specif</i>	v)
n of		Ju: T	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Injur Wor	y at			w injury occurr		
Sio	Attending r death. sctor: After by the fune	catio	2 Accident investigation				M 1 🗆	Yes 2□N	10				
Division	iel or Attendii s after death. si Director: A sd in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place o	f Injury - At h g, etc. <i>(Specil</i>	ome, farm, str fy)	eet, factory, office		28	Bf. Location (St City or Town	reet and Numb n. State)	ər or Rura	d Route Number,
	Hospitel or 24 hours afte Funerel Dir tely filled in I		29a. Certifier 1 Certifying Pr	vsician: To the h	est of my kno	wiedne death	nocurred at the tir	ne date and	place on	ad due to the e	21100/0) and mo		hatad
	ne Hospitel or n 24 hours afte ne Funerel Dire bletely filled in b	edical	(Check only 2 Medical Exer	niner: On the bas and manne	is of examina	ation and/or in	vestigation, in my o	pinion, death	n occurred	d at the time, d	ause(s) and ma ate and place, a	nner as si and due to	tated. the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier				29c. Licens			2	9d. Date signed	i (Month,	Day, Year)
)	1		1 meg	- WD			()52	113		March	٦	2035
	1)		30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type,	Print)	Bal	h	~^2	21202	>	
			31. Date filed (Month, Day, Year)	32 Pa	istrate Signs	ature :		- 0. (1 10				
	Sta Registr		MAR 0	4 2005	Bloom	w St.	Sperke						

			1 - State Amend It	em 23	State of Ma , pt . II,	aryland 25,27,	/Depa 28a-f	rtment per tificate	of He	alth and 845, 7-2 leath	Mental Hy 28-05 ta	ygiene S Reg. No.	2000	0710
	Physici		1. Decedent's Name (First, Mic	die, Last)		CHR					2. Date of D FEBRU	eath	- 4 4 9	3. Tinle of Death)
	/Medic Examin		4a, Fecility Name (If not institut	ion, give stre				4b. City, T	own, or L	ocation of Dea	ith		County of Dea	
				MARI		10SPi		14115-44	15A		TORE		N/A	
ı	Funeral Director		5. Social Security Number 216-96-2924	6. Sex 1.⊠ №	7. Ag	9 (In yrs. las 39	Yrs.	If Under 1 Months	Days	If Under 24 Hr Hours Mir		orth 1965 1965		thplace (State or Foreign ountry) RYLAND
	land		Usual Residence of Decedent 10a. State 10b. Cour	ty		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mary First	ţō	MD BAI	TIMOR	E	T	OWSON							1 ☐ Yes 2 X No
	th the	Director	10e. Street and Number					10f. Zip (Code			10g. Citi	izen of What C	ountry?
	23a c	ai	1670 YAKONA F	ROAD				21	286			U	SA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Miccical Exaciliar most be redified at ance.	by Funerai	11. Marital Status 1 ☑ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorc	arried	. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ ! If Yes, Give Year or Dates:		l l	Was Decede 1 Yes, specif 1 ☐ Yes 2	fy Cuban,	panic Origin? (Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	10-	14. Race - Am- Black, Whi Specify: Tult	
9	2 hour	edt	15. Deced	ent's Educat	tion		16a. Deced	ient's Usual	Occupati	ion		16b. Ki	ind of Business	
21215-0036	hin 72 nn "na Medis	Completed	(Specify only high		ompleted) College (1-4or 5		(Give	kind of work DO NOT use	k done du	ring most of w	orking			,
	filed wit Hygiene other the	Com	N/A				N	/A					N/A	
and	be fill d off	Be	17. Father's Name (First, Middle		6061m 411	***			1		ame (First, Middi		,	
7	should nd Mer marke	٦ ا	WILLIAM FRAM 19a. Informant's Name/Relatio				10b Mailie	a Addross ((Street an		L. WAR			Zin Codel
Maryland	id 2 sith an 27 is r		WILLIAM F. CO					YAKO			WSON, M		286	21p C00e)
	s 1 and f Health item 27 other to	1	20a. Method of Disposition	······································	,	20b. Plac	e of Dispo	sition (Name	e of		Date		ocation - City or	Town, State
Ë	Pages nent of int: If it iry or o	1	1 ☐ Burial 2 ☑ Crematio 1 ☐ Donation 5 ☐ Other		noval from State	1		MATOR		1	4/2005	CAT	ONSVILI	LE. MD
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service	ce Licensee	man		22	. Name and	Address	of Facility 1		SON F	UNERAL	HOME, P.A. 1286
Н			23a. Part1. Enter the disease, shock, or heart failure	or complica	tions that caused	I the deeth.	_							Approximate Interval Between
	Physician		23a. Part 1. Enter the disease, shock, or heart failure, L. Immediate Cause (Final disease or condition		Chok	ing or	1 a fo	od bo	lus	with co	mplicat	ions		Onset and Death
п	/Medical Examiner		resulting in death)		Due to (or as	a conseque	nce of):				/			
Na St	* *	er	Sequentially list conditions if any, leading to immediate	b	Due to (or as	a conseque	nca of).				1			
1	nted Insit	mine	cause. Enter Underlying Cause (Disease or injury	≺ .							M			
Ć	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	C.	Due to (or as	a conseque	nce of):			11/	11 1. 1		MINER	
8760,	ysicia	dlcai		d						4	/UMU	MEDICALEX	YM.	
Θ		0	IF FEMALE:							TICATI.	MADPROVED BY			
.O. Box	that the death certificated by the attending posterior detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	230	. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3	Ectopic pre Other (spe	egnancy ecify)	CERTIFICA	· · · · · · · · · · · · · · · · · · ·		23d. Date of de Month	Day Year
<u>α</u>	res that igned b	by Pt	Part II. Other significant cond	itions contri	buting to death b	ut not resulti	ng in the u	nderlying ca	use giver	in Part I.	23e. Did	tobacco u	ise contribute l	o the cause of death?
rds	w require been sig should b		Mental retard	ation	Dyspha	gia					1 🗆] Yes 2 [□No 3□P	robably 4 Unknown
Vital Records,	The lar	Completed									per	opsy formed?		utopsy findings available completion of cause of
ita		0	25. Was case referred to medi	cal						26. Place of De	1 X Yes eath (Check only		1 19:	20,110
of V	S 0 =	To B	examiner? 1 TyYes 25(No	Hos	spital: Inpatio	ent 2 EF	VOutpatien	t 3 DOA	Other	4 Nursing	Home 5□Re	sidence (6 □Other (Spe	acify)
o u		on:	27. Manner of Death TENaturat 5 ☐ Pen	ding	28a. Date of Inju (Month, Da	ry y Year) 2:	8b. Time of Injury		3c. Injury a Work?		28d. Describe	e how injur	y occurred	
isio	ten leat tor: the	cat	2 Accident inve	stigation Id not be	2-17-05		10	A ^M		es 2 No	Choked			and On the Manager
Division	i or Attendater deatl	Certification:	4 Homicide dete	mined	28e. Place of Inj building, et	c. (Specify)	e, idilli, Str	eet, ractory,	omice		City or T	own, State	⁷⁷⁰⁸ 1	ural Route Number, 1iddlesex
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai C	29a. Certifier TS Certification (Check only one)	ying Physic al Examine	ian: To the best r: On the basis o and manner st	of my knowle f examinatio	edge, death n and/or inv	n occurred a	it the time	, date and place	e, and due to th	e cause(s)	more Co and manner a place, and du	s stated.
)	To the within To the comple	Med	29b. Signature and title of cert	fier			~ID	29c.	License	number 589	13	29d. Date	te signed (Mon	th, Day, Year) y 27 200
	2		30. Name and address of pers	on who com	pleted cause of o			Print) (000	CA	MARI-	TANI	HOS	PITAL
	V		MANISHA 15	HHL	MD	56	001	Loca	H	RAVE	N BOU	LEYF	ny,	BALTIMOR
	Sta		31. Date filed (Month, Day, Ye	ar)	32. Registr	s Signatur	re	1	d .					21239
DL	Regist		MAF	04	32. Registr	Corner	J.F.	Agan						

Privision Total content Privision				1 - For State of Maryland / Dep	partment of learning		ental Hygie	/1115	07191
Examiner Renaissance Candens Second Security Name of five designed, only the state and number) Second Security Name of five designed, only the state of the st		Dhuniai		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
Principal Direction Principal Direction						F	ebruary		
Second Security Number Second Security Number Second	1	Examin	er						
The part of the							9 Date of Righ		
Special Plant Special Plan		Director		220-42-6775 1□M 2∏F 90 Yrs.		Hours Min.	(Month, Day, Ye	914 Mary	rland
Special Plant Special Plan		yland how		10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
Special Plant Special Plan		8a-1 s	ctor	Maryland Baltimore Catonsvi	.lle				1 ☐ Yes 2√7 No
Special Plant Special Plan		th with th	al Dire						•
Special Plant Special Plan	36	rs after dea I', or Itams	by Funer	1 ☐ Never Married 2 ☐ Married Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	If Yes, specify Cub	oan, Mexican, Puerto R	ify Yes or No- ican, etc.)	Black, White	e, etc.
Special Plant Special Plan	215-00	nin 72 hou n "natura Vedical E	pleted	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occu re kind of work done DO NOT use retire	pation during most of working ad)	g 16t	o. Kind of Business/l	ndustry
Special Plant Special Plan	212	d with giene giene ar tha	Com	12 0 college (1-461-5+)	rse		h	ospital	
Physician (Modical Examiner) 23a. Part. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Bio Crised and Int	land	uld be file Aental Hy rked oths tic evant	ro Be (den Sumame)	
Physician (Modical Examiner) 23a. Part. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Bio Crised and Int		nd 2 sho aith and N 27 is ma rr trauma		19a. Informant's Name/Relationship (Type, Print) Carolyn Cox – daughter 19b. Mai 2800	iling Address (Stree Quebec S	t and Number or Rural Street NW #	Route Number, C. 210 Was	ity or Town, State, Z hington,	ip Code)
Physician (Modical Examiner) 23a. Part. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Bio Crised and Int	nore,	Pages 1 a ent of Hee nt: if Itam y or othe		1 XBurial 2 Cremation 3 Removal from State	ematory or other pla	ice)	ite 200	. Location - City or	
23a. Part I. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximation of the disease of complication resulting in death) Complete of the disease of condition resulting in death)	Baltir	permit. F Departme Importar any injur		21. Signatur of Funeral Service Vicenses	22. Name and Addre	ess of Facility Hub	bard Fu	neral H	ome, Inc.
Moderation Comparison Com				23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Sequentially list conditions of any leading to immediate cause. Enter Underlying Cause (Disease or injury Cause (Disease	7	/Medical		disease or condition resulting in death)					Years
The property of the property o	ı	Examiner							
State Part		n =	ner	if any, leading to immediate Due to (or as a consequence of):					
State Part		ecuter and trans	cam	Cause (Disease or injury that initiated events c.					
FFEMALE: 23b. Was deceded pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	60,	be ex ician burial	al E	Due to (or as a consequence of):					
Section Sect		icate physi s the	dlc	d					
The state of the s	Вох	death certii ne attending ed for use a	sician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5		y			*
The state of the s	P.0	at the	Phys	9 Unknown					
The state of the s		equires then signed ould be d	by	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause gr	ven in Part I.			,
The state of the s		The law nate has be bage 2 sh	omple				autopsy	prior to c	ompletion of cause of
The state of the s	ita	sien: artifica ctor.				26. Place of Death (
The state of the s		hysic this call dire	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3L DOA	4 Nursing Home			ify)
The state of the s	nc	ding F	tlon:	- Distriction	Wo	rk?	d. Describe how it	njury occurred	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Division	or Attenuatter deatl Diractor: in by the	ertifical	3 Suicide 6 Could not be			8f. Location (Street City or Town, St	t and Number or Rui tate)	ral Route Number,
		Hospital 24 hours Funaral itely filled		(Check only 2 Medical Examiner: On the basis of examination and/or i	ath occurred at the ti	me, date and place, an opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
		vithin o the omple	Mec		29c. Licen	se number	29d.	Date signed (Month)	, Day, Year)
30. Name axe address of person who co releted cause of death (Item 23a) (Type, Print) Mula M Oxroxytor MD 711 Moliden Charice In Cottonswille Mo	1	- AF 0		mala ma	D 37	989	Ent	20 10 10 1 3	ans Es
		10		30. Name ave address of person who colleted cause of death (Item 23a) (Type	Print)	hairs 1) Cota	naud 1	Mo
State Registrar MAR 0 4 2005 32. Begistrar's Signature			_	31. Date filled (Month, Day, Year)	hades				1,10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 205 c per fb 8841 3-9-05 vt 20a Mental Hygiene
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Coleman OZ Zers /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner G/com Anundel HOS pitel Anne Arud North Glenn Bukwe If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign 5. Social Security Number 6. Sex 8. Dete of Birth (Month, Day 9. **Funeral** Days Months Hours 78-882 10 M 20 F Yrs. Director Usual Residence of Decedent County 10c. City, Town or Location 10a. State 10b. 10d. Inside City Limits •how : if item 27 is marked other than "natural", or items 23e or 28s-1 show or other traumatic event, the Modical Examinar must be notified at 1 1 Yes 2 □ No Directo Maryand 7
10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? α Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other traumatic event, La Monee. Be 17. Father's Name (First, Middle, Last) 18: Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be 0 Ver emai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 1 Durnie $\Delta \Pi$ altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State unk Mt. Carmel 3-9-05 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Md tack permit 21. Signature of Funeral Service License 22. Name and Address of Facility Home Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 21 Approximate Interval Between Onset and Death shock or heart failulemediate Cause (Final disease or condition resulting in death) **Physician** Retronket Intection /Medical Due to (or as a consequence of): **Examiner** VIRENUC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed ecursist heumonia Bronchiectasis attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, annest IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 4 Unknown 1 Yes 2 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 Yes 2 No 1 Tes 2 No or Attending Physician: director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 LevOutpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this, mpletely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 WNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 273199 (N4) o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 2 ho imes anche sinar th 1830 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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ORIGINAL

Aspet !

		1	For State Registrar	State of Maryland	d / Department of Health and Certificate of Death	Mental Hygien	2000	07193
	Physicia	an	1. Decedent's Name (First, Middle, La	(ash)		2. Date of Death Month Da	ay Year 2005	3. Time of Death O 4; 47AM
May may	/Medic Examin		la. Facility Name (If not institution, gir	re street and number)	4b. City, Town, or Location of Deat		c. County of Deat	h
	Funeral Director			Sex 7. Age (In vrs. II 1XM 2□ F	st birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birt 500	chplace (State or Foreign ountry) (44) (Groling
	ryland thow		Usual Residence of Decedent 10a, State 10b, County	10c. City	r, Town or Location			10d. Inside City Limits 1XYes 2 □ No
	ith the Ma or 28a-f	Directo	10e. Street and Number		Utt More	10g. C	itizen of What Co	
	r death w	Inerall	+712 A Ihou	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
0036	hours afte ural', or l'	d by Fi	1 □ Never Married 2 □ Married 3 Widowed 4 □ Divorced	Year or Dates:	1 ☐ Yes 2 ☑ No Specity:	16h	Specify B Kind of Business	lack
21215-0036	itled within 72 hours after death with the Maryland Hygiene. the than "natural", or tlems 23a or 28a-f ehow ont, the Medical Examiner must be notified at	Completed by Funeral Director	15. Decedent's E (Specify only highest gi	College (1-4or 5+)	Give kind of work done during most of wo	rking 155	me B	wilder
	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Las	2000)	18. Mother's Na	me (First, Middle, Maide	n Sumame)	19
Maryland	s mand	F	19a. Informant's Name/Relationship	(Type, Print) (SON)	19b. Mailing Address (Street and Number or R	ural Route Number, City	or Town, State, 2	Zip Code) 21212
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 I		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	lace of Disposition (Name of semetery, crematory or other place)	B/4/05 T	Location - City or	Town, State
Baltir	permit. Pag Department Important: eny injury o	İ	21. Signature of Funeral Service Lice		22) Name and Address of Facility Variable 46 16 2 2 2 16 16	ve tive	ral Se	ruices
70	Physician		shock, or heart failure. List onlinediate Cause (Final	one cause on each line.	n. Do not enter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequ				7 2045
	uted d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dualitz (or as a consecu	Janas J):			
68760,	ate be executed hysician and the burial-transit	ical Exa	resulting in death) Last	Due to (or as a consequent	uence of):			
Box 68	death certifical e attending phy od for use as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna			23d. Date of de	livery Day Year
P.O. B	0 0 2	Physiclan/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of do 9☐ Unknown		OG- Didahan		o the cause of death?
Ś	The law requires that the tite has been signed by thoage 2 should be detache	by	Part II. Other significant conditions	contributing to death but not rest	ulting in the underlying cause given in Part I.	1 □ Yes		robably 4 @Unknown
Record		Completed				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of 2 kg No
Vital	ilcian: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	Other	eath (Check only one)	C [] (St / (S /	
ō	g Phys er this ieral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 □ DOA	Home 5 Residence 28d. Describe how in		ecity)
Division	tel or Attending F s after death. el Director: After ed in by the funer.	Certification:	1 ■ Natural 5 □ Pending 2 □ Accident investigat 3 □ Suicide 6 □ Could not determine	on be as Place of Injury - At he	M 1 ☐ Yes 2 ☐ No ome, farm, street, factory, office	28f. Location (Street: City or Town, Sta		ural Route Number,
ā	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in h		29a. Certifier 1 @ Certifying	Physician: To the best of my kno	owledge, death occurred at the time, date and plac tition and/or investigation, in my opinion, death occ	e, and due to the cause	(s) and manner a	
	o the Hi ithin 24 o the Fi omplete	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Mon	
	->-0		the fine	2 - M)	AT2438946	-E6 M.	rch, 02	-,2005
_	H		30. Name and address of person when Ali Esmaili U	o completed cause of death (Item	Hospital 201 East Unive	ersity Parkwa	1 Bultime	re, mo 21218
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 4	32. Redistrar's Signa	Hospital 201 East Unive			

			1 - For State Registrar	State of		id / Depa		t of H	ealth a	and M	lental Hyg		005	07191
			Decedent's Name (First, Middle, L	.ast)							2. Date of Dea	ith	000	3. Time of Death
	Physici		FLORENC	E		(COHEN				Month Februar	y 28,	2005	6:50 P M
	/Medic Examin		4a. Facility Name (If not institution, g		ver)		4b. City,	Town, or	Location	of Death			unty of Death	
	Examin		Greater Baltim	ore Medic	al Cen	ter		To	wson			Bal	timore	2
	Funera!			Sex 7.		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	B. Date of Birth JAN. 13,	Year)	9. Birth	place (State or Foreign
п	Director		053-09-8028	1□M 2∏F	88	Yrs.	Months	Days	Tiours	IVIII 1.	JAN. 13,	1917		NY
	pu ,		Usual Residence of Decedent 10a. State 10b. County	<u></u>	100 0	ty, Town or Lo	antion							10d Incide City Limite
	shov	_		TIMODE	100. 011	-		_						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	Sct		TIMORE		BAL	TIMOR							
	with th	Ē	10e. Street and Number	10 DOAD			10f. Zip	Code	010	111		10g. Citizen	of What Cou	-
	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show the Martical Exerciter must be rictified at	Funeral Director	2119 N. ROLLIN		an Francis II	0 10	W D		212		-	14	Race - Ameri	USA
	ltem Item	in l	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede	es?	.5. 13.	If Yes, spec	ify Cuba	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)	14.	Black, White,	etc.
36	rs aft	by F	3 X Widowed 4 □ Divorced	1 Tes 2 If Yes, Give Year or Date			1 ☐ Yes 2	2M No	Specify:			Spi	ecity:	WHITE
ဝို	ture ture	ed	15. Decedent's			16a. Dece	dent's Usua	I Occupa	ation			16b, Kind o	of Business/In	ndustry
5	n n	Completed	(Specify only highest of	rade completed)		(Give	kind of wor DO NOT us	rk done d se retired,	luring mos)	t of work	ing			•
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B	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, La	st)					18. Mothe	er's Name	e (First, Middle,	Maiden Sur	name)	
Maryland 21215-0036		To B	HARRY			FIE	RST		BEL	LA				SIEFERT
ary	should and Mer s marke umetic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address	(Street a	and Numbe	er or Run	al Route Numbe	r, City or To	wn, State, Zip	Code)
	and 2 Balth a n 27 ls		JAY COHEN / SC	N		211	9 N. I	ROLL	ING F	ROAD	- BALTI	MORE,	MD 21	244
re	es 1 a of He of He rothe		20a. Method of Disposition	Me		lace of Dispo cemetery, crea	sition (Nam	ne of ther place	e)	-	Date	20c. Locati	on - City or To	own, State
Ĕ	Pages nent of int: If It		1 🕅 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special	(Днетоval from St	ate	. HEBR	-			03/03	3/2005	FLUS	HING,	NY
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Lic	ensee		22	2. Name an	d Addres	s of Facili	ty SC	L LEVIN	SON &	BROS.	. INC.
Ö	Depa Depa Impo any i		1 last				8900	REIS	TERS1					MD 21208
			23a. Part1. Enter the dispase, or co shock, or beart failure. List on	mplications that cau	sed the deat	th. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory are	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(-	11100	cil.	F1110	oh	01.	00/1	4/11			Onset and Death
	/Medical		resulting in death)	a. Due to (or	as a conseq	juence of):		7714		410	1100			1 4 clevel
П	Examiner		Convention to list conditions	, E	ces	sine	G	1 1	Ble	eel				aweek
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consec	uence of):								•
	cutec	Examin	Cause (Disease or injury that initiated events	c										
760,	ate be executed nysician and he burial-transit	Ĕ	resulting in death) Last	Due to (or	as a conseq	(uence of):							i	
876	ate b hysic the bi	licai	•	d										
68 89	e as	Physician/Med	IF FEMALE:		CIRC STR									
Вох	ath c	ian/	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Feta	ıl death 3	Ectopic pr					23d.	Date of delive	ery Day Year
0	the a	sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4∐ Pregnar 9⊡ Unknow	nt at time of com	leath 5	Other (sp	ecity)						
<u>ď</u>	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Ph	Part II. Other significant conditions	contributing to deal	th but not res	sulting in the u	nderlying c	ause dive	en in Part I		23e. Did to	bacco use o	contribute to t	he cause of death?
ds,	signe d be	l by		•	.,				21.01		1 U Y	es 2XN	o 3∏ Prot	pably 4 □Unknown
Ö	v requir been s should	Completed									-			
Sec.	elaw hast	ğ						-			24a. Was a autop	sy	prior to co death?	opsy findings available impletion of cause of
ᆵ												2 No	1 🗆 Yes	2□ No
Ž.	Physician: r this certifica ral director, i	å	25. Was case referred to medical examiner?	Hospital: , 况				A Othe	No.		n (Check only or			
ot	Phys this ral dii	-T	1 Yes 2 No	28a. Date of		ER/Outpatier 28b. Time o		^	4 🗆 140		me 5 Resid			(y)
5	ding After fune	lo Lo	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injury	м	8c. Injury Work	c? Yes 2 🔲		200. 00001100 11	ow inquity ou		
isi	Attending r death. ector: After	ical	3 Suicide 6 Could not	be Blace of	f Injury - At h	ome, farm, sti				-	28f. Location (S	treet and N	umber or Rura	al Route Number,
Division of Vital Records,	lor A after Direct	Certification:	4 ☐ Homicide determine	building	etc. (Specia	(y)	oot, lactory	, 011100			City or Tow			
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying	Physician: To the b	est of my kno	owledge, deat	h occurred	at the tim	e, date ar	nd place.	and due to the o	ause(s) and	manner as s	tated.
	e Ho 24 h e Fur letely	edical	(Check only 2 Medical Ex	aminer: On the bas and manne	is of examina	ation and/or in	vestigation,	in my op	oinion, dea	th occur	ed at the time, o	date and pla	ce, and due t	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	13 6			290	. License	number		2	29d. Date sig	gned (Month,	Day, Year)
	, J F 0			X	_>		D	(018	844	-		0110	3/05)
•			30. Name and address of person wh	o completed cause	of death (Iter	m 23a) (Type,	Print)	4						
	V		Dicupa Los	2 MD	(05	65 N	. Cha	irli	2) -	St.	Tow	Son	MD	21204
	Sta	ite	31. Date filed (Month, Day, Year)	32.	istrar's Signa	ature	- 100							
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			WALL A		-	-								

DHMH 17 Rev 1/2001

Conen. Floreng

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month 02 2005 **Physician** 8:40p Larinoff Denwick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring 13848 Turnmore Rd. Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Day, Year 09-02-1915 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Illinois 1 ☐ M 21SIF 345-05-9353 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Exon for most be notified at 1 Yes 2 No Director Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1614 Tweed St. 20851 Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23sury or other traumatic event, the Madical Expt. For matal. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank Clerk Banking 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Larinoff Mary Popov Larinoff ం 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13848 Turnmore Rd. Silver Spring MD 20906 Paula Driscoe (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 20 Cremation 3 ☐ Removal from State Chesapeake Crematory 02-24-2005 permit. Page Department of Important: If any injury or once. Beltsville MD ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services M00382 933 Gist Ave Silver Spring MD 20910 let dolun ann Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastati Physician 1000 CARCE months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 south C. 5 Nu. 2 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🗗 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 20148 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Dolinsky 911 Russell Ave Gaithersburg MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department 1- For Amend Item#26, perDVR, G841, 3/4/05 reflections	t of Health and Menta e of Death	l Hygien Reg. N	°2005 07196
4	Physici /Medio			2. Date Mor		Day Year 0 3. Time of Death 0 2005 0845 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Howard County General Hospital Co	Town, or Location of Death lumbia Tyear If Under 24 Hrs. 8 Date	e of Birth	Howard 9. Birthplace (State or Foreign
24	Funeral Director		5. Social Security Number 348-32-1616 Usual Residence of Decedent	Days Hours Min. (Mor	nth, Day, Yea 18,1	r) Country)
	e Maryland a-f show iilied al	ctor	10a. State 10b. County 10c. City, Town or Location Maryland Howard Columb	ia		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Director	106. Street and Number 107. Zip 11112 Swansfield Road	21044	10g. C	Citizen of What Country?
036	within 72 hours after death with the Maryland one. than "netural", or Items 23s or 28s-f show tha M. diral Exami he must be multied at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced 1 Vietnam 1 Yes	dent of Hispanic Origin? (Specify Yes off Cuban, Mexican, Puerto Rican, e 2 No Specify:	s or No-	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 ho giene. or than "netura the Mudical B	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ School Co	ark done during most of working se retired)	Ва	Kind of Business/Industry ltimore blic Schools
Maryland	should be filed nd Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Russell Duncan	18. Mother's Name (First, Faye Jessee	e	
altimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f show mith injury or other treumatic event, the Modral Examinar must be notified at DDGs.		Janet Duncan (Wife) 20a. Method of Disposition 1 🗵 Burial 2 Cremation 3 Removal from State Columbia Memo	other place)	lumbia 20c.	
Balti	permit. Departm Importar any inju		21. Signature of Funeral Service Licensee . 22. Name ar	nd Address of Facility		ia, Maryland 21045
8760,	Physician pe executed unding physician and unding physician and as the purial-transit	licai Examiner		diac ar	ryt	Interval Between onset and Death onset and Dea
Box 6	ath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery Month Day Year
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ital	Thate page	Be Co	25. Was case referred to medical	1	Yes 2□N	
of	Q. 5.	ုင	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D		Residence scribe how in	ury occurred
Division	ē	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	City	or Town, Sta	
	the Hospitel nin 24 hours the Funerel npletely filled	ledical	29a. Certifier Check only one) Certifying Physician: To the best of my knowledge, death occurred the basis of examination and/or investigation and manner stated.	at the time, date and place, and due , in my opinion, death occurred at the	to the cause(time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complet	×	29b. Signeture and title of certifier	DO658	29d. D	2 / / 05
	100		30. Name and address of person who completed cause of death (Item 22a) (Type, Print) Webvin JKorum IIII 9501 Cl	annagals N	00	I Ellipat
**	Sta Regist		31, Date filed (Nonth Dan Year) 2005	7-51		2104/1

			1 - For State	• •	aryland / Dep		of H	ealth a	and M	ental Hy	giene	00!	·	07197
			Registrar 1. Decedent's Name (First, Middle, Las	t)		- Intolate				2. Date of De.	Reg. No." ath			3. Time of Death
	Physici	an	MARGARET S. DIL							Month MARC	Day	200	ar	9:30 PM
	/Medid Examir		4a. Fecility Name (If not institution, give			4b. City. T	Town, or	Location o	of Death	17/110		County of D		0.00 111
	Exami	lei	MANOR CARE-TOWS			1	WSON					ALTIMO		
	Funeral		Social Security Number		ge (In yrs. last birthda)) If Under		If Under 2	24 Hrs.	8. Date of Birt	h Vaar	9. 1	Birthpla	ce (State or Foreign
	Director		217-01-6805	⊒м жО Кғ	91 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da April 7	, 191	3 V:	irqi	inia
	pr ,		Usual Residence of Decedent		La su -									
	aryla.	_	10a. State 10b. County	_	10c. City, Town or I		C.						100	d. Inside City Limits 1 ☐ Yes 2√0(No
	88-f	octo	Maryland Baltimor	e 	Di	ltimor		JUITLY						
	vith th	Dire	10e. Street and Number 4219 Thorncliff R	لم ا		10f. Zip (236			10g. Citiz	en of What	Countr	у?
	s 23e	Funeral Director			5	W 5			. 0 (0	77 17 11				to diag
	item Item	in.	11. Marital Status 1 ☐ Never Married ※※ Married	12. Was Decedent Armed Forces? 1 Yes 20X	Ever in U.S.	If Yes, speci	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)		 Race - A Black, W 	mencar /hite, et	n indian, c.
36	irs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes 2	⊠ No	Specify:				Specify: W	hite	9
Ö	fillad within 72 hours after death with the Maryland Hygiene. uther than "natural", or liems 23a or 28a-f show ont, I're Medical Examires the motified at	ted	15. Decedent's Ed	ucation	16a. Dec	edent's Usual	Occupa	tion				d of Busine		
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21	d with giene er the	Completed	12 yrs.	2 yrs.		ales Pe	ersor	1			R	etail		
b	e fila at Hy oth	Be (17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden S	Surname)		
<u>/la</u>	Wents Wents wrked wrked	2	James Trader					Druc	тта	Tyler				
Maryland 21215-0036	iges 1 and 2 should be filad within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, If a Madical Examiner was be notified at		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ling Address ((Street a	nd Numbe	or or Rura	l Route Numbe	r, City or	Town, State	e, Zip C	Code)
	1 and Health em 27 thar tr		Earl H. Dill, Sr.	(Husband		3 Thorr	ncli	ff Rd		ltimore	, Md	. 212	36_	
ore	of Holl iter		20a. Method of Disposition XIXI Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Disp cemetery, cr	oosition (Name ematory or oth	e of her place)		ate	20c. Loc	ation - City	or Tow	n, State
Ĕ	nit. Pages artment of h ortant: If ite injury or of		*4 □ Donation 5 □ Other (Specify		Loudon Pa	ark Cem	nete	ry 3	-5-2	005	Balt	imore	, Mo	d
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	4	l i	22. Name and	Address	of Facility	y Home	2				
ш	207299		23a. Part1. Enter the disease, or comp	saln						e timore,		2123	6	<u> </u>
1760,	/Medical Examiner	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if anv. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c.	a consequence of): a consequence of): a consequence of):	EUS	0	Eng	En	71A				Onset and Death
P.O. Box 68	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at 9⊡ Unknown	2 ☐ Fetal déath 3 t time of death 5	□Ectopic pre □ Other (spe	cify)	n in Part I.		23e. Did to		3d. Date of o Month	Di	ay Year
sp.	urres Isign	d by	WrosEPSIS							1 □ Y	es 2 🗆	No 3□	Probab	oly 4 Unknown
Records,	w requir been si should	Completed						-		24a. Was	an	24b. Were	autops	y findings available
Re	The lav	m d								autop perfor	med?	prior t death	o comp	oletion of cause of
Vital			25. Was case referred to medical					26 Place	of Doath	(Check only or	2 No	1 🗆 Y	es 2	∐ No
>	Physician: this certitional director,	To Be	eyaminer?	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	ent 3□ DOA	Othor		-	ne 5 ☐ Resid		□Other (St	necify)	_
o	<u>a</u> ≠ <u>a</u>		27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time		c. Injury	at		8d. Describe h			poony)	
<u>o</u>	ndin ath. r: Aft	atio	Natural 5 Pending 2 Accident investigation	(Worth, Da	y Year) Injury	М	Work?	es 2□N	No					
Division	or Attendater deati	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj	ury - At home, farm, s	treet, factory,	office		2	8f. Location (S City or Tow		Number or	Rural F	Route Number,
	tal or	Cer		January 6					10.	o.i.y o	., 0.0.07			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the tuner	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exemption	rsician: To the best iner: On the basis o and manner st	of my knowledge, dea f examination and/or i ated.	th occurred at nvestigation, i	t the time in my opi	e, date and nion, deatl	d place, ai h occurre	nd due to the o	ause(s) a late and p	nd manner place, and d	as state	ed. ne cause(s)
	To t To t	Σ	29b. Signature and title of certifier				License			2	29d. Date	signed (Mo	nth, Da	y, Year)
}			Water to	mus		D	239	150			31	3/01	2	
	10		30. Name and address of person who o	ompleted cause of d	leath (Item 23a) (Type	, Print)	4	1,						
	10		CURTER HEON	En 540	5 CHURC	HLA	14	YDE	5 h	1D 2	108	2		
	Sta		31. Date filed (Month, Day, Year)	22. Registr	ar's Signature	de l								
	Registr	ar	MAR 0 4 2005	per la la la la la la la la la la la la la	15. 1970									

amend item#5, perFit, G841.3/22/05 Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Will 23 Junious Daniel Feb. 2005 23:42P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton P.G. Southern Maryland Hospital tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3 y | 1948 5. Social Security Marsh 6 224-60-3916 Birthplace (State or Foreign Country)
 VA 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □XM 2 □ F 57 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits Charles Md. Accokeek X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15613 Maple Drive 20607 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Brick Self-Employed 12 Mason 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Evergreen McCargo Silas Daniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15613 Maple Drive
Accokeek, Md. 20607

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky Branch Bap.
Church Cemetery 3/2/05 Wylliesburg, 19a. Informant's Name/Relationship (Type, Print) Seletheia Daniel/wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State permit. Page Department of Importent: if eny injury or once. injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD.20746 cawara 23a. Pakel. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner espera Sequentially tist conditions iner cause. Enter Underlying Cause (Disease or injury that initiated events certificate be executed burial-transit Janes and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the d detached o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ the 2 No 3 Probably 4 □Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a Was an has page 2 certificate 1 ☐ Yes of Vital 2√No funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ٩ 1 Unpatient 2 ER/Outpatient 3 DOA 27. Manner of Deat 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Division 1 Natural trijury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 0 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00052865 Fes 7005 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) where 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 04

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARCH 9:50 PM 2005 oanna /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ature C mewood 6 8. Date of Birth
Month, Day, Year 36 South Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Birthplace (State or Foreign Country) Months 213-34-0544 Usual Residence of Decedent Days Hours Min. 1 □ M 2 X F Director with the Maryland 10b. County 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a madical Example Train Le notified at 10d. Inside City Limits 1 Yes 2 No Directo more Varyland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "nany injury or other traumatic event, it is Mad Elementary/apcondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame ames 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, lowanda 170 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ R
14 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Garrison tores 21. Signatur of Funeral Service Aicensee 22. Name and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician HRONIC RENAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ABETES MELLETUS 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ^oL 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28b. Time of 28c. Injury at Work? Certification: After 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: in 24 hour. 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MID

gitrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

32.

LECNARD PICHARDSON

04

31. Date filed (Month, Day, Year)

PSTT

5602 BACTIMORE NATIONALAKE #603

MARCH

				partment of Health and Mental Hy ertificate of Death	ygiene 2005 07200
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last) Henry Firstenberg 4a. Fecility Name (If not institution, give street and number)	2. Date of D Month Te bruce 4b. City, Town, or Location of Death	Day Year
	Funeral Director		Shady Grove Adventist Hospital 5. Social Security Number 128-28-6728 6. Sex 153 M 2 F 69 Yrs.	Rockville If Under 1 Year	Montgomery 9. Birthplace (State or Foreign Country) 8, 1935 New York
	ne Maryland 8e-f ehow	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits 1 ⊠ Yes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Exatiginal rutst be notified at once.	Funeral Directo	10e. Street and Number 821 Jonker Court 11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married	10f. Zip Code 20878 3. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	10g. Citizen of What Country? United States 10- 14. Race - American Indian, Black, White, etc.
21215-0036	thin 72 hours al en "netural", or Meulcal Exam	Completed by I	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify: bedent's Usual Occupation ve kind of work done during most of working DO NOT use retired)	Specify: White
Maryland 21;	uld be filed wit Mental Hygiens Irked other the	To Be Com	17. Father's Name (First, Middle, Last) Jack Firstenberg	Lear Physicist 18. Mother's Name (First, Middle Sadie Eisman	Government Contracting e, Maiden Sumame)
re, Mary	ss 1 and 2 sho of Health and N item 27 Is ma other treums		19a. Informant's Name/Relationship (Type, Print) Myriam Firstenberg/Wife 20a. Method of Disposition 19b. Mai 82 20b. Place of Disposition	iling Address (Street and Number or Rural Route Numb 21 Jonker Court, Gaithers position (Name of Date rematory or other place) March 1	
Baltimore,	permit. Pages Department of I Importent: If ite any injury or or once.		'4 □ Donation 5 □ Other (Specify)	remainly of other place) nery Drium, Inc. 2005 22 Name and Address of Facility 3 Pert 1. Cockville, Inc. West 1. Rockville, Maryland 20850	Bethesda, Maryland Fumphrey Funeral Home/ Ontgomery Avenue, -2805
	Priysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory a	
8760,	icate be executed by physician and physician and sthe burial transit and physician streams trans	dical Examiner	Sequentially list conditions, framy leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a nonsequence of): Due to (or as a consequence of):		
O. Box 6	The law requires that the death certifica tte has been signed by the attending ph page 2 should be delached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	: □Ectopic pregnancy : □ Other (specify)	23d. Date of delivery Month Day Year
ords, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
/ital Record	ysicien: The law is certificate has l director, page 2 s	Be Completed	25. Was case referred to medical examiner?	24a. Was auto perfic 1 □ Yes 26. Place of Death <i>Check on</i>	prior to completion of cause of death? 2 → No 1 ∨ Yes 2 ∨ No
Division of Vital	To the Hospitel or Attending Physicien: within 24 hours after dearth. To the Funerel Director: After this certifica completely filled in by the funeral director;	Certification; To	1 Yes 2 No	of 28c. Injury at Work? M 1 Yes 2 No	how injury occurred
DİN	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	ledical Certifi	4 Homicide determined determined 256. Place or injury: At nome, fairin, s building, etc. (Specify) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in the	City or To	(Street and Number or Rural Route Number, wn, State) cause(s) and manner as stated.
	To the within 2 To the complet	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	20		30. Name an address of person who completed cause of death (Item 23a) (Type	CE RUND #213 GATheres	ury MD 20577
	Sta Registr	tė ar	31. Date filed (Month Day, Year) 2005 32. Ingistrar's Signature	back	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 245 pm **Physician** Month Yee beraldine 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Bayview Baltmore C If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/30/1917 Birthplace (State or Foreign Country)
 Texas Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min. 1 ☐ M 2 🖸 F 461-32-8201 87 Director Usual Residence of Decedent 10a. State
TEXAS 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artiment of Health and Mental Hygiene. attiment of Health and Mental Hygiene. Outlett; if frem 2.21s marked other than "naturel", or thems 2.3e or 28e-1 show injury or other treumatic event, its Medical Expretizations to the profilled at Laurel DALLAS 1 ☐ Yes 2X No Director MD Howard 10e. Street and Number 2610 MARBURG STREET 10f Zin Code 10g. Citizen of What Country? 20725 USA 9305 All Saints 75215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ➡ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Day Care Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sterling Robinson Margie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Robinson 9305 All Saints Road Laurel, Maryland 20723-1703 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) LINCOLN CEMETERY 2/18/05 DALLAS, TEXAS 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. Depart Import any inj 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner eomyelitis of the Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? rascula 1⊟ Yes 225 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 T Homicide within 24 hours a Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) write mo Buyview 5505 Hopkins

Registrar

State

31. Date filed (Month, Day, Year)

MAR 0 4 2005

32. Registrar's Signature

			1 - For Registrar	State of M	faryland / De <i>C</i>	partment of F ertificate of			6007	07202
	Physici		1. Decedent's Name (First, Middle, La	st)	GE			2. Date of Death Month	Day Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give	e street and number			r Location of Death	itu	4c. County of Dear	th
	Funeral Director		1	Gex 7. A	ge (In yrs. last birthda	Monthe Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Bird	thplace (State or Foreign buntry)
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
	after death with the Maryland or items 23a or 28s-1 show outrer could be recitized at	Director	MARYLAID 10e. Street and Number	11A		10f. Zip Code	LTIMO		. Citizen of What Co	1 Yes 2 No ountry?
8	death ims 23	Funeral [5005 S u	NSET 12. Was Decedent Armed Forces	ROAD t Ever in U.S. 13	3. Was Decedent of H	2/2/ lispanic Origin? (Spe		US 14. Race - Ame	erican Indian,
3y//i		þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced	1 Yes 2 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:	rican, etc.)	Specify: B	e, etc. LACK
25. 25.	within 72 hours ene. than "natural", he Medical Exe	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Gi	cedent's Usual Occupi ve kind of work done o DO NOT use retired	during most of workir. d)	g 16	b. Kind of Business/	
, p	2 should be filed within 7 and Menial Hyglene. Is marked other than "n aumatic event, the Med	Be Con	10 TRGRADE 17. Father's Name (First, Middle, Last)		LAFETE	18. Mother's Name			PUBLIC SCHOOLS
<i>พา ดิ</i> ธ Maryland	should b nd Ments marked umatic e	Tof	JOHN 19a. Informant's Name/Relationship (Type, Print)	G E E 19b. Ma	iling Address (Street a	HAZE and Number or Rural	Route Number, C	GIBS	
	1 and Health tem 27 other tr		CAROLYN HARRIS	50N (COL	15IN) 40 20b. Place of Dis	50 CAR	THAGE	RD. RAN		J.MD. 21133
	Page ent o nt: if ry or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	ý)	cemetery, ci	rematory or other plac	(a)			
Baltii	permit. Departm importal any inju		21. Signature of Furleral Service tates	ISOO V		22. Name and Address	FULTO	N AVE	BALTO. 1	WW, MD. AL HOME 40 21217
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each I	ine.	inter the mode of dying	g, such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		s a consequence of):	veril (5)	r corg	ancer		1 ward P
42	uted d ansit	Examiner	Sequentially list conditions, if my learn to the cause. Enter Underlying Cause (Disease or injury	b. Due to (or ##	s a consequence of):					
8760,	cate be executed physician and the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequence of):					
9	phy:	/Medical	IF FEMALE:	. d.	of proposition					
P.O. Box	requires that the death certific een signed by the attending p hould be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deli- Month	very Day Year
ds, P.	ires that the de signed by the a 3 be detached to	by.	Part II. Other significant conditions of	ontributing to death b	out not resulting in the	underlying cause give	en in Part I.		co use contribute to	
Records,	aw Is b	Completed	Hypertension					24a. Was an	2 No 3 Pro	topsy findings available
T E	Thate ate	0	COPD 25. Was case referred to medical				26. Place of Death		? death? No 1 ☐ Yes	ompletion of cause of
Division of Vital	hya his	To B	examiner? 1 Tes 2 No 27. Manner of Death	Hospital: 1 X Inpatio	ry 28b. Time	of 28c, Injury	ar: 4 ☐ Nursing Hom		e 6 Other (Spec	ify)
ision	Attending r death. sctor: After by the fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ay Year) Injury	Work M 1 □ Y	í? ∕es 2 □ No			
Div	ospital or A hours after uneral Dire		4 Homicide determined		jury - At home, farm, s c. (Specify)			City or Town, S	·	
	the H nin 24 the F nplete	Medical	one)	ysician: To the best niner: On the basis o and manner st	of my knowledge, dea of examination and/or in ated.	nvestigation, in my op	inion, death occurred	at the time, date	and place, and due	to the cause(s)
	Mith To Con		29b. Signature and title of certifier Karusau N	O reven	0.	RES			Date signed (Month,	, ,
	W		30. Name and address of person who	completed cause of d	2401 W.	Belvedere	LAvenue	Baltin	nove M	2005 D 21215
	Stat Registra	56.	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature			, , , , , , , , , , , , , , , , , , , ,		_, _,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please T	ype or Print in Bla	ack Ind	delible Ink.	Ensure Al	I Copies /	Are Legible.	
		1 - For State Registrar	State of Maryland	•	rtment of F		Re	g. No.ZUU5	07203
Physicia		1. Decedent's Name (First, Middle, Last) Gilbert A. Gib	son				2. Date of Death Month May Vell	Day Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give s			0 . 1	r Location of Death	71147075	4c. County of Dea	th
Funeral		5. Social Security Number 6. Sex			If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign
Director		216.40. 0995 128 Usual Residence of Decedent	M 2 F 62	Yrs.	Months Days	Hours Min.	bl. Dc.	1943	ountry) MD
Maryland show	tor	10a. State 10b. County	10c. City, T		eation timone)			10d. Inside City Limits 1 🗹 Yes 2 🗆 No
th with the 23a or 28a	al Director	10e. Street and Number 4313 Fairfax	Road		10f. Zip Code	21216	10	g. Citizen of What Co	ountry?
0 0 0	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ∯yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 PNo	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B	e, etc.
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", any injury or other traumatic event, If a Medical Exu- once.	eted	15. Decedent's Educ (Specify only highest grade	cation 1 completed)	(Give I	ent's Usual Occup	during most of worki	ng 1	6b. Kind of Business	Industry
d within piene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2 VEQ (5	IITO. L	DAY P	oller		Janito	rial
be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	laiden Sumame)	
thould id Men marke	ဥ	Marion Gibson 19a. Informant's Name/Relationship (Type	ne. Print)	19b. Mailin	Address (Street	and Number or Rura	A Route Number.	City or Town, State, 2	Zin Code)
and 2 sealth ar n 27 is			on Nife 12	1313	Fairfe	x Rd. E	Baltini	re MD 2	1216
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permit. Pa Departmen important any injury once.	İ	*4 □ Donation 5 □ Other (Specify) 21. Signal are of Funeral Service Licens		22	Mount Name and Addre	1			
Depa impo any ir once		Vangh (1	15	51 Baltin			services le Balto. N	
Pnysician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	eations that caused the death. It is cause on each line.		ir the mode of dyin	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death 2 4 Hours
/Medical Examiner			Ole to (or as a consequen	ce of):	,				2 Weeks
pe ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	0	1	K.I.			2
be executed ician and burial-transit	Examiner	that initiated events c.	Due to (or as a consequent		encl.	- 6) /VI	re 1		Lyers)
pa icia	ē	C d.	Hepol?	7,5	C 1	Intel.	Tion		20 years
To the Hospital or Attending Physician: The law requires that the death certificate butthin 24 hours effer death. To the Funeral Director: Atter this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	by Physician/Medic	IF FEMALE: 23 Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de: 4 □ Pregnant at time of death 9 □ Unknown	ath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
quires that in signed b	ed by PI	Part II. Other significant conditions cont	tributing to death but not resultin	g in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to s 2 No 3 □ Pr	
itcian: The law re certificate has bee rector, page 2 sho	Completed					<u> </u>	24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
iclan: sertifica ector, I	Be	25. Was case referred to medical examiner?	ospital:		Othy	26. Place of Death		/	
To the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tion; To	27. Manner of Death Natural 5 Pending 2 Accident investigation	1 Inpatient 2 DEFIV	Outpatient b. Time of Injury	28c. Injun Worl	/at 2	ne 5 Resider 28d. Describe hov	ce 6 Other (Spector)	erfy)
at or Atten efter deal i Directora d in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,
n 24 hours n 24 hours ne Funera	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Cartifying Chysical Exemination (Check only one)	ician: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the timestigation, in my of	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
To the Comp	ž	29b. Signature and title of certifier	6 000)	29c. License	number	29	d. Date signed (Mont/	n, Day, Year)
'n		30. Name and address of person who con	mpleted cause of death (Item 23	a) (Type P	Print)	1728	1	12/20	03
7		Robert K. Roby	MO 2433	Mr	STBelve-	lepe Ave	SUTE 22	BeHomore	E1616 an
Stat Registra		31. Date filed (Month, Day, Year) MAR 0 4 2005	32. Registrar's Signature	22482	9				

			State of Maryland / Department of Health and N	Mental Hyg	iene (05	07204
			1- State Registrar AMEND ITEM #3 PER PHY G841 Settificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of Deat	eg. No.		3. Time of Death
	Physici		Mable M. Gonje	Month	Day	Year 2005	2:42p M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. Count	y of Death	
			Howard County General Columbia			Hono	
١.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State or Foreign Iry) Jamaica
			Usuel Residence of Decedent	100 13.1	1 6-6-		
	the Marylar 28a-f show	٦٢	10a. State 10b. County 10c. City, Town or Location Columbia			10	od. Inside City Limits 1 ☐ Yes 2 ② No
	the M	ecto	10e. Street and Number 10f. Zip Code	1	0g. Citizen of	What Count	
	23a or	i Di	5860 Thunder Hill Road 21045			ISA	.,,,
	within 72 hours after death with the Maryland ene. then "natural", or Itams 23a or 28a-f show then "matural Examinating at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (St. 14 Marital Status) 14. Was Decedent of Hispanic Origin? (St. 15 Marital Status)	pecify Yes or No-		ce - America	
36	rs afte	y Ft	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specity: Year or Dates:	•	Specia	. 1	ick
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of B	10 11	
215	ithin 7	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)		Alcal	Van	Chalo
	filed w Hygier othar th	CO	17. Father's Name (First, Middle, Last) 18. Mother's Nam	ne (First, Middle, M			State
lan	buld be filed with Mental Hygiene. arkad othar than atic avant, than	To Be	Samuel Dewar Ezild		+		
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Maryla nt of Health and Mental Hygiene. If itam 27 is markad other than "natural", or Itams 23a or 28a-f show or other traumatic avant, the Medical Examinar must be indiffed at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rule)		City or Town	, State, Zip	Code)
	1 and 1 Health am 27 ther tr		Joyce Gowie - Gamble 22109 Highview Tra			uni	VA 21148
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.		1 Nurial 2 Cremation 3 Removal from State cemetery, crematory or other place)	8.05	20c. Location	mbia	
altin	permit. Pag Department Important: I any injury c		CONCINE				
ä	Depar Impor any ir	7 1	21. Signature of Funeral Service Licensee 22, Name and Address of Facility Valuation C. Greene SISUBALTIMETE NAT	Timal Pik	e Boul	timore	MO 21229
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart allure. List only one cause on each line.	or respiratory arre	est,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Myplandia Interction			1	Onset and Death
	Examiner		Due to (pr as a consequence of):				
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	icate be ex physician s the buria	dicai E					
9	tificate ng phys as the	Medic	Leseville.				
Вох	death certifics attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mogths? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			ite of deliver	y Day Year
P.O. I	that the death ed by the atte detached for	ysic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown				July 10u
	res that the igned by be detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use con	tribute to the	a cause of death?
Division of Vital Records,	w require been sig should b	ed b		1 □ Ye	s 2 🗆 No	3 Proba	bly 4 Unknown
ecc	ne law re has be ge 2 sh	Completed		24a. Was ar autops	V	prior to com	sy findings available pletion of cause of
a H	ician: The certificate h			perform 1 ☐ Yes 2	ned? A No	death? 1 ☐ Yes	2□ No
Vit	Physician: this certificanal director,	o Be	examiner? Hospital:	th (Check only one		(0	
J Of	g Phys er this eral di	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Reside 28d. Describe ho			
sior	Attending I death. ctor: After y the funer	catio	2 Accident investigation M 1 Yes 2 No				
)ivi	after d Diract Jin by I	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town		per or Rural	Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page		29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,	and due to the ca	use(s) and ma	anner as sta	ited.
	To the Hospita within 24 hours To the Funaral completely filled	edical	(Check only and manner stated.	red at the time, da	ite and place,	and due to	the cause(s)
	Tot	M	29b. Signard e and title of certifier 29c. License number	29	d. Date signe	d (Month, D	ay, Year)
7	(6		930706	4	L- 10		
	17	/	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 246. License number 7 16 7 8 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 246. License number 7 16 7 8 6 31. Date filed (Month, Day, Year) 0.0 5 32. Registrar's Signature	in Park,	MD.	2122	>
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 4 2005				

			1 - State Registrar AMRND ITEM			epartment of G <i>ertificate</i> (of			giene ()	05	07205
	Physici	ian	Decedent's Name (First, Middle, Landson L	ast)	1111 004	1 3/09/09	,	2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Media Examir		Hazel L. G 4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	or Location of Death	62	28 4c. County	of Death	10:17pm
	•		Gilchrist Hospin	ce			LTIMORE			N/A	
	Funeral Director			Sex 7. Age (1 □ M 2 5 F	(In yrs. last birth	Months Dave		8. Date of Birth (Month, Day Olo! 1 (r, Year)	9. Birthpl Count	lace (State or Foreign try)
	iryland show	_	10a. State 10b. County	1 22	IOc. City, Town	54°				10	Od. Inside City Limits
	the Ma 28e-f	ecto	10e. Street and Number	timore	150	Itimore)					1 □ Yes 2 Sublo
	th with 23e or	al Dir		K Court		10f. Zip Code	244		10g. Citizen of V	Vhat Count	:ry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23e or 28e-f show any injury or other treumetic event, If a Madical Examiner is ust be notified at once.	Completed by Funeral Director	11. Marital Status 1) ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of If Yes, specify Cult		ecify Yes or No- Rican, etc.)	Blac	America k, White, e	etc.
5-0	72 ho "netur	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. D	Decedent's Usual Occu Give kirid of work done ife. DO NOT use retire	ipation during most of worki	na	16b. Kind of Bu	siness/Ind	ustry
2121	d within jiene. r then	omp	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Jears	7	ife. DO NOT use retire			Hea	th	Care
Maryland 21215-0036	be filed stal Hyg od othe event,	Be	17. Father's Name (First, Middle, Last			,	18. Mother's Name			9)	
aryle	should nd Mer marke	70	John Lee GV 19a. Informant's Name/Relationship		19b. N	Mailing Address (Stree	LUCIII		City or Town	State Zin (Code)
	and 2 ealth a n 27 is		Betty Alexand	er/Aunt	74	52 Catter	ick Cou				ID 21244
Baltimore,	ages 1 nt of H t: If item / or oth		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	TI TOTTO TOTT OTATO	20b. Place of D cemetery,	Disposition (Name of crematory or other pla			20c. Location -	-	
altin	permit. P Departme Importeni any injur;		'4 □ Donation 5 □ Other (Special Signature of Fune 2) Service Lice		FT. 4	22. Name and Addr	and in	4.05	Brent		-
<u> </u>	80E # 8		Vanch (*		51St Baltir	pore Natu	unal Pika	e Boutu	nore 1	1021229
	Pnysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final				1		est,	1	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	aDue to (or as a c		is System	cy my no	W.S.			year
	Cxammer	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence of	:					
\$	acuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate sause. Enter the environment of Cause (Disease or injury that initiated events	c							
,60	ificate be executed g physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a c	onsequence of)	:					
052	rtificate ng phy: as the	dedical	IE EENALE.	. d							
2/38/ P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 SNo 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 Ectopic pregnanc 5 Other (specify)	у		23d. Date Mon	of delivery	y Day Year
S, ∃	es that igned b	by Ph	Part II. Other significant conditions					23e. Did tob	acco use contri	bute to the	cause of death?
1017PM Records,	w require	eted	Human com or	luna de t.	ciency	U.rus S	rndvermi	1 □ Ye	s 2,22 No	3 Probat	bly 4 □Unknown
. =	ilcien: The law certificate has rector, page 2 (Completed						24a. Was ar autops perform 1 Yes 2	y pr ned? de	ere autops ior to comp ath? Yes 2	sy findings available pletion of cause of
HAZEL n of Vite	ysicien: ils certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpa	atient 3 DOA Oth	26. Place of Death ner: 4 ☐ Nursing Hom		111	(Conside)	Hospica
HA	ing Ph	on: T	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye		ie of 28c. Injur	ry at 2 rk?	8d. Describe ho			1105/010
Nisic	l or Attend after death Director: / in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of Injury	- At home, farm	M 1, street, factory, office	Yes 2 No	8f. Location (Str	eet and Numbe	r or Rural F	Route Number.
SICAHAM	oitel or At urs after o rel Direci	Cert	4 E Homicida	building, etc. (S			W.	City or Town	,		
96	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Properties 2 Medical Example 1	ysician: To the best of m niner: On the basis of ex and manner stated	amination and/c	eath occurred at the tir or investigation, in my o	me, date and place, as opinion, death occurre-	nd due to the ca d at the time, da	use(s) and man ite and place, ar	ner as stat nd due to th	ed. he cause(s)
	To the within To the To the Comp	Me	29b. Signature and title of certifier	10		29c. Licens		-	d. Date signed		
	(i))	30. Name and address of person who	mpleted cause of death	h (Item 23a) (Tv		205		Narch	•	1000
9	U		W. A. Riley	GBMC	6701	pe, Print)	Ces St. B.	alte. 11	IN Zu	205	
:	Sta Registra		MAR 0 4 2005	32. Registrar's	Signature	2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 11 15

			1 - For State Registrar	State of Ma	arylan		artment rtificate					Reg. No.		5	07	206
	Physicia	an l	1. Decedent's Name (First, Middle, Last	9						1	Date of De. Month	ath Day	, Y	ear	3. Time	of Death
	Physici /Medio		Malinda Dolo	ores Gra	nger						MARCH	2	2005		7:3	OAM
	Examir		4a. Facility Name (If not institution, give				4b. City, To			f Death		4c.	County of	Death		
	انسب		SAINT AGNES T						OPE	2411						_
	Funeral		5. Social Security Number 6. Se	ox 7.Age ⊒M 2b☑F		last birthday) 5 Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birl (Month, Da	h y, Year)	[Coun	itry)	e or Foreign
	Director		Usual Residence of Decedent		8	3 11%					April 7	,19	19 M	ary.	land	
	land		10a. State 10b. County		10c. City	y, Town or Lo	cation							1	Od. Inside	City Limits
	Many	ō	Maryland Anne Aru	ındel	Pa	sadena									1 🗆 Y	es 2⊠No
	28a	Director	10e. Street and Number			<u> </u>	10f. Zip C	Code				10g. Cit	izen of Wha	at Coun	itry?	
	3a o		843 Defranceaux	K Harbour				2112	2				U.S.	Δ		
	ms 2	Funeral	11. Marital Status	12. Was Decedent B	Ever în U.	S. 13.				gin? (Spec	cify Yes or No lican, etc.)	. T	14. Race -	Americ		,
9	or Ita	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	10	t	1 ⊡ Yes 2		Specify:	, rueno n	ilican, etc.,		Black, Specify:	vvriite,	etc.	
93	ours raft,	d by	3 ☐ Widowed 4 🔀 Divorced	Year or Dates:	11 /2		103 2	20110	эрвену.				эрөспу.	Wh	ite	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Itams 23e or 28e-1 show the Madical Examiter could be notified at	Completed	15. Decedent's Ed (Specify only highest grad			16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa done di	tion uring most	of workin	g	16b. Ki	ind of Busir	ness/Ind	lustry	
121	han her	d m	Elementary/Secondary (0-12)	College (1-4or 5	+)			retirea)				т.				
2	filed v Hygie othar t		12 17. Father's Name (First, Middle, Last)				Clerk		18 Mothe	r's Name	(First, Middle,		nsura	nce		
anc	nould be fi I Mental H narked ot natic ever	Be	Otto Strippy										Camanoj			
Ž	2 should be filed within and Mental Hygiene. Is marked othar than eumatic event, the Ma	မှ	19a. Informant's Name/Relationship (T	ivne Print)		19h Mailir	na Address (Street a			Frank Route Number		r Town St	ate Zin	Code)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other then "natural", or Items 23a or 28a-1 show any Injury or other treumatic event, the Marical Extratrial must be multified at once.		Donald A. Granger									-				1.00
	permit. Pages 1 and 2 Department of Health Important: If itam 27 any Injury or other tre once.		20a. Method of Disposition	(3011)	20b. P	lace of Dispo	efrancesition (Name	e of		Dour			Mar cation - Cit			122
Jō.	Pages nent of I ant: If its ary or o		1 Burial 2 ☐ Cremation 3 ☐			emetery, crei	-			2 -	2005	n 1			LESS S	
Baltimore,	artme ortan njury		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License 			udon P	Name and	Address	of Facility	/			timor			
Ba	permit. Departr Importa any Inji		23a. Part 1. Enter the disease, or composhock, or heart failure. List only of	olications that caused	the death	\ Y	itzke 630 Ed	Fund	eral ison	Home Ave.	of Cat Catons respiratory ar		ville le, M	ary.	nc. Land Approxim Interval E Onset an	nate Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. END ST			AL DI	SEA	SE							ARS
	/Medical Examiner		19suiting in death)	Due to (or as			. 9							2	O Y	EARS
		_	Sequentially list conditions,	b. HYPE			7							- 1		CITTO
	pet Inslt	Examiner	cause. Enter Underlying Cause (Disease or injury													
	al-tra	xar	that initiated events resulting in death) Last	Due to (or as a	a consequ	uence of):										
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687	ficate p phy:			U												
Box	death certificate be executed e attending physician and of for use as the burlal-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			- · ·						23d. Date o	f delive	ry	
ğ	death a atte d for	cla	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at			∃Ectopic pred ∃Other <i>(sped</i>						Month		Day	Year
0	that the de ned by the a detached f	hys	9 🗆 Unknown	9 Unknown												
Records, P.	86 200	by	Part II. Other significant conditions co	ntributing to death bu	ut not resi	ulting in the u	nderlying cau	use give	n in Part I.			obacco u res 21	ise contribu ⊒No 3{	ite to th □ Prob		of death? Unknown
CO	w requires been si should I	Completed									24a. Was		24b. We	re autor	osy findini	gs available
Re	9 4 6	E C										rmed2	dea	r to cor th? Yes	npietion o 22No	f cause of
Vital	icien: Th certificate rector, pag	Ö	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes (Check only o	2/2 No		195	21/2 140	
5	Physicien: r this certifica ral director, p	To B	examiner?	Hospital:	nt 2 🗆	ER/Outpatier	nt 3 DOA	Othe			e 5 ☐ Resid		6 ∏Other	Specify	()	
of	a Phy eration		27. Manner of Death	28a. Date of Injur (Month, Day		28b. Time o		c. Injury Work			3d. Describe			-,,		
lon	Attanding Is death. actor: After by the funer	atlo	Natural 5 Pending 2 Accident Investigation	(MOHIII, Da)	/ 1 dai/	Injury	М		es 2□N	No						
Division	or Attandii after death. Diractor: A in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At ho c. (Specify	ome, farm, str y)	eet, factory,	office		28	8f. Location (5 City or Tox			or Rura	Route No	umber,
_	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edical Co		ysician: To the best of tiner: On the basis of and manner sta	examina											e(s)
	o the	Mec	29b. Signature and title of certifier				29c.	License	number			29d. Dat	e signed (/	Aonth, I	Day, Year)
	ĕ → ₹ →			D. MD			MARKY, MARK	PI	206	07		MA	RCH	2, 2	2065	7
	1		30. Name and address of person who d	/	eath (Item	1 23a) (Type	Print)			-			, _ , ,	, .		
9	\		PONNA BILV	900 0	ATO	NAV	ENUE	Ē	BALT	Mo	PE, M	ARY	ILAN	D	212	29
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 4 200	5 Side Cons	ar s signa	ture do	whi									

DHMH 17 Rev 1/2001

JOLOPES M GRANGER

			1 - For State Registrar	5	State o	of Maryl	and / Depa		nt of H te of L				gienę Reg. No.	005	07207
			1. Decedent's Name (First, Middle	, Last)								2. Date of Dea Month	ith Dey	Year	3. Time of Death
	Physicia		BERN	TCE		М.	GUY					Feb.		2005	4.35 P
	/Medic Examin		4a. Facility Name (If not institution		eet and nu				y, Town, or	Location	of Death			unty of Death	
	EAGIIII.		Caldabasa Dak	h	0 ht		~ Conto	- C	-1:-1	h	Má	J	T _a :	7 .	
	Funeral		Salisbury Rel 5. Social Security Number			7. Age (In	yrs. last birthday)	If Und		Ollry	24 Hrs.	8. Date of Birth	Yearl	li comi	place (State or Foreign
	Director		213-20-7766	1 □ λ	1 2 [X] F		95 Yrs.	Month	Days	Hours	Min.	8. Date of Birtl (Month, Day August 1,	1909	Mary	land
			Usuel Residence of Decedent												
	ylan		10a. State 10b. County			100	. City, Town or Lo	cation							10d. Inside City Limits
	Mar F-f-s-	tor	Maryland Wid	comic	20				Sal	isbur	CV				1 ☐ Yes 2√ No
	128c	Director	10e. Street and Number					10f. 2	ip Code		-1		10g. Citizer	of What Cou	intry?
	3a o	E D	27890 Cross Cre	ek I	rive				21	801				USA	
	filed within 72 hours after death with the Maryland Hygiene. Ither than "netural; or items 23a or 28e-f show ent, it a Medical Examiner must be notified.	Funeral	11. Marital Status		. Was Dec	edent Ever	in U.S. 13.	Was Dec			igin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Ameri	ican Indian,
	r ite	Ē	1 Never Married 2 Marri	ied	Armed F	2 🛛 No						ritali, etc.)		Black, White	
3	urs aur, o	b	3 XWidowed 4 ☐ Divorced		If Yes, G Year or I	ive Dates:		1 LI Yes	2⊠ No	Specify:			Sp	ecify: W	hite
	2 ho	Completed	15. Decedent	's Educa	tion	1	16a. Dece	dent's Us	sual Occupa	ation	t of work	ina	16b. Kind	of Business/Ir	ndustry
	hin 7	pie	Elementary/Secondary (0-12)	yraue C		/ (1-4or 5+)	life.	DO NOT	vork done d use retired))	1 01 110110	9			
-	d wit	ШО	6					Н	omemal	ker				Own J	Home
2	othe ent.	BeC	17. Father's Name (First, Middle,	Last)						18. Moth	er's Name	e (First, Middle,	Maiden Su	mame)	
Q	ld be enta ked ic e	0	Asbury Middleto	n						Mar	y Co	rbin			
_	should be nd Mental marked c	-	19a. Informant's Name/Relationsl	hip <i>(Typ</i> e	, Print)		19b. Maili	ng Addre	ss (Street a	and Numb	er or Rura	al Route Numbe	r, City or To	wn, State, Zi	p Code)
<u> </u>	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene a febow filem 21 is marked other than "netural", or items 23a or 28e-f show other treumatic event, if a Meulcal Examiner mant be notified at		Honey I Car / C	'on l			27800) Cr	oga C	rook	Dein	0 001	i ab		vland 2180
Ú	1 ar Hea Hem tem		Henry L. Guy (S	on)		20	Ob. Place of Dispo	osition (A	lame of	eek	DETA	e - Sal	20c. Locat	fon - City or T	own, State
5	Pages nent of not: if it iny or o		1 ☑ Burial 2 ☐ Cremation		noval from	State	cemetery, cre				Dala	27 200	\5 D	.11 Ma	Lara I a va d
	그 문문을		* 4 □Donation 5 □ Other (S) 21. Signature of Fundal Service		1	7	well Chu							TI' MG	iryrand
<u> </u>	permit. Departimport any inj		Mauselle	Oe/SX	ac (t	with						neral Ho			
	202 0 0		Mary Beth B 23a. Part1. Enter the disease, or									- Crist		MD_21	817 Approximate
			shock, or heart failure. List	only one	cause on	each line.	death. Do not en	(er (ne m	ode or dylin	y, such as	cardiac c	or respiratory ar	1621,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ a	Xu	200	Cano	2						-	malh
	/Medical		resulting in death)		Due to	o (or as a co	nsequence of):			_	(1	10		4 -	
	Examiner		Sequentially list conditions.	b.	Eg o	na	of	110	cele	me.	- 00	yours.	Ray o	Servez	V year
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	cute	am	Cause (Disease or injury that initiated events	c.	\nearrow	4/2	27 + 20	000	~						1001-
Ś	an a an a rrial-1		resulting in death) Last	ı	Due to	(oras a co	nsequence of):							1	
0/0/0	cate be executed physician and s the burial-transit	dicai		d.	/										
0															
Š	w requires that the death certiff been signed by the attending should be detached for use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant	230		utcome of pr		Tectonic	pregnancy				230	. Date of deliv	-
•	death le atten	icia	in the past 12 months?		4☐Preg	gnant at time		Other						Month	Day Year
j	oy the	Physi	9 Unknown		9□ Unk	nown									
r.	requires that the reen signed by th hould be detache	by P	Part II. Other significant condition	ons contr	ibuting to	death but no	t resulting in the u	inderlyin	g cause give	en in Part	1.	23e. Did to	bacco use	contribute to	the cause of death?
3	uire; sig											4 ا	es 2□N	lo 3 🗆 Pro	babiy 4 Unknown
2	w req	Completed										24a. Was	an 2	4b. Were aut	opsy findings available
บ	e la has je 2	ш										autop		prior to co	ompletion of cause of
33	pa ate											1 Yes	à□16	1 Yes	2□ No
VII CO	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		spital:				Oth	05		h (Check only o			
5	Physical this call dir	2	1 Yes 2 40	1,10	1 _		2 ER/Outpatie		DOA	4 (4)		me 5 Resid			ify)
	m m 0	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	ng	(Mo	e of Injury onth, Day Ye	er) 28b. Time o		28c. Injur			28d. Describe h	low injury o	ccurred	
Sion	Attending or death. ector: After by the fune	Certification:	2 Accident investig	-				М		Yes 2					
<u> </u>	irect irect	Ħ	3 Suicide 6 Could 4 Homicide determ	nined	28e. Plac	ce of Injury - ding, etc. (S	At home, farm, st pecify)	reet, fact	ory, office			City or Tou	otreet and N m, State)	iumber or Hui	al Route Number,
	rs aff	Cer													
	hou hou uner						y knowledge, dea mination and/or in								
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fun	Medical	one)	A		nner stated.									
	To t To t	Σ	29b. Signature and title of certifie	1/	1/			1	29c. Licens	e number	7	(1)	29d. Date s	igned (Month,	, Day, Year)
	\bigcirc		1/1/1	3/1	1-				02	29	54	1	4	5/61	
	1	+	30. Name and address of person	who com	pleted car	use of death	(Item 23a) (Type	Print)			-	-	1	4	
	V								7. * * ~	C-	1 4 - 1-	111077 14	a ^	1004	
	St	ate	William Robir 31. Date filed (Month, Day, Year)	05	M. 32.	Registrar's	200 Ci	VIC.	_A ve.	, , 5 d.	LLSD	ury, M	u. 2	1004	
	Pogiot		MUAR U 4 ZU	U3	NEW	100	r Addition								

BERNICE Guy

				State of Ma						-		_	15-	
			1 - Stete Registrar			Cei	rtificate	of De	ath		Reg. No.	とししら	0	7208
	hysicia	20	1. Decedent's Name (First, Middle, Last	")			61	1665		2. Date of De Month	Day	y Year		Time of Death
	/Medic		DELMA							FUBRUH		21 200		3:06 AM
E	xamin	er	4a. Facility Name (If not institution, give		4.)		1	own, or Loc	ation of Deat	n	4C.	County of Dea	tn	
Eu	neral		JOHNS HORKINS 5. Social Security Number 6. Se	x 7. Ag		ast birthday)	If Under 1	Year If	Under 24 Hrs	8. Date of Bir	th Your		thplace	(State or Foreign
	ector		212-12-1431	□M 2☐F	84	Yrs.	Months	Days H	lours Min.	8. Date of Bir (Month, Da MARCH	23,	1920	ountry)	MD.
pur	200		Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or La	ocation						10d. lr	nside City Limits
Maryla	r sho	ō	MD. N/A				ALTIMO	ORE						Yes 2 □ No
the !	nodii	Director	10e. Street and Number				10f. Zip (10g. Citi	izen of What C	ountry?	
th with	238 0	alD	155 S. GRUNDY STRE	ET					21224			U.S.A	•	
ar dea	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		5. 13.	Was Decede If Yes, specif	ent of Hispa fy Cuban, N	nic Origin? (S lexican, Puer	pecify Yes or No to Rican, etc.)	0-	14. Race - Am- Black, Whi	te, etc.	
rs afte	. 0.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ X If Yes, Give X Year or Dates:	NO .		1□Yes 2	No S	pecify:			Specify:	TIHW	ľΕ
be filed within 72 hours after death with the Maryland ital Hygiene.	ed other than "natural", or items 23a of 28a1 snow event, the Medical Extrainer marke rediffied at		15. Decedent's Edi (Specify only highest grad	ucation		16a. Dece	dent's Usual	Occupation	n ng most of wo	rkina	16b. Ki	ind of Business	/Industry	у
ithin 7	Med	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use	e retired)	,g 111031 01 1101	g		UNKNO	1.7N1	
led w	nt, th		12TH 17. Father's Name (First, Middle, Last)		1		UNICI		Mother's Nar	ne (First, Middle	, Maiden		MIN.	
d be f	marked other than matic event, the M	To Be	CHARLES KOCH					1	MARGAR	·				
2 w =	m 3	-	19a. Informant's Name/Relationship (T	урө, Print)		19b. Mailir	ng Address ((Street and	Number or Ru	ıral Route Numb	er, City o	or Town, State,	Zip Code	θ)
and 2	n 27 li ler tra		LAHANA CLAYTON-SM	ITH/FRIEN					ST., BA	LTIMORE				
ges 1 t of H,	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	BAL'I	ace of Disport	osition (Name matery of oth WASH)	e or INGION	1	Date		ocation - City or		
t. Pa	rtant: njury		 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service License 			CREMA	TORY	Address of	MARC	CH 1,200 MARLES S				
permit. Pages 1 and 2 Department of Health a	any ir		21. Signature of Pulleral Solvice License	- FILE	ens					, BALTI				
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death								App	roximate rval Between
Phys	ician		Immediate Cause (Final disease or condition			MES	TIMAL	- BL	EED.	LIKE	LY		Ons	et and Death
	dical niner		resulting in death)	Due to (or as							,			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	ence of):								
uted	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.										
e be executed	ian ar urial-ti	I Ex	resulting in death) Last	Due to (or as	a consequ	ence of):								
cateb	ed by the attending physician and detached for use as the burial-transit	dical	•	d										
certifi	nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of de	livery	
death	e atte	icla	in the past 12 months? 1 ☐ Yes 2 ② No	1□Live birth 4□Pregnant at 9□Unknown			□Ectopic pre □ Other (spe					Month	Day	Year
at the	by the	Physiclan/Med	9 Unknown			Min - i - M			- Port I	22e Did	lobacco	use contribute to	o the car	use of death?
ires th	should be deta	by	Part II. Other significant conditions co	nthouting to death b	out not resu	sung in ine u	indenying ca	use giveri ii	I Fall I.					4 □Unknown
y requ	shout	letec								24a. Was	an	24b. Were a	utop <i>s</i> y fi	indings available
Pe la	SE CA]	ompleted								auto perfe	ormed?	death?		ion of cause of
ian:	is certificate ha	Be C	25. Was case referred to medical examiner?						. Place of De	ath (Check only				
hysic	this ce aldire	2	1 ☐ Yes 2 No	Hospital: 1 2 Inpatio		ER/Outpatier		1	4 Nursing H	lome 5 Res	***		cify)	
d filling P	After t funera	lon	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Inju (Month, Da		28b. Time o Injury	M 28	3c. Injury at Work? 1 ☐ Yes	2 □No	28d. Describe	now injur	у осситеа		
Attenc	actor: After the by the funeral	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inj	jury - At ho	me, farm, str						d Number or R	u <i>ral R</i> ou	ite Number,
s after	ਕੋ.⊆	Certi	4 Homicide	building, et	ic. (Specity)				City or To	wn, State	"		
To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.	To the Funeral Diractor: completely filled in by the		(Check only 2 Medical Exem	sicien: To the best iner: On the basis o	f examinat	wledge, deatl ion and/or in	h occurred a	it the time, o	date and place on, death occu	e, and due to the arred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the o	cause(s)
o the	To the complet	Medical	29b. Signature and title of certifier	and manner st	ated.		29c.	License nu	ımber		29d. Dat	te signed (Mon	h, Day,	Year)
F	- ŏ		> Rota RICA	erani 1	MD			RES	-000		FEB	RUARY	21	2005
h			30 Name and address of person who o	completed cause of o	leath (Item	23a) (Type,	Print)	N. N	0.4					2122:
5			· · · · · · · · · · · · · · · · · · ·	MI 4940	eas	STERN	V AVE	NYE	BILT	MORE	MAR	CYLAM?	> ×	1424
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registr	ars olgnat	The party	sele!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registramend ITEM #19a PER FH C841 3/04/05 JH Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Year **Physician FEBRUARY** 25 2005 HELENE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 05/04/191919 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 K F MA 85 016-12-3540 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show traumatic ayant, the Medical Examiner must be notified at 10LOSMITH, HELENE 2025.05 Baltimore, Maryland 21215-0036 1 □Yes 2 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 805 HOPEWOOD ROAD 21208 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Anned Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE ō 1 Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) SOCIAL SECURITY al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ADMINISTRATION MEDICAL CLAIMS EXAMINER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental F ed bluods **GLASER** JESSIE ROGERS **JACOB** Propagant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If itam 27 is y or othar trai MURRY GOLDSMITH / HUSBAND 805 HOPEWOOD ROAD BALTIMORE, MD 21208 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 Burial 2 Cremation 3 Removal from State permit. Page Department of important: If any injury or once. 03/03/2005 | OWINGS MILLS, MD MARYLAND VETERANS ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. C. Kuso 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Edward 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) syndrome Physician Years Myelodysplastic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 metastatie cancer unknown 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Tother (Specify) NOSPLCE 1 Yes 2 No ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 2 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 24 hours a Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hc To tha Fun completely (29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Atthe of certifier February 25-200;

Registrar DHMH 17 Rev 1/2001

State

6601 N-Charles

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mon charces mo

Year)

31. Date filed (Month, Day, Yea MAR 0 4

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"Sir Pondin mo 21204

amend item/195, per 1961, 3/4/05 TT State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Gemina Hall 01:13 AM Bessie 02 05 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4h. City Town or Location of Death **Examiner** Prince Georges Regional Hospital Laurel aurel If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 ☐ M 2 🖾 F Months Days Hours 97 Yrs. 214-34-386 MD 05.17.190 **Director** Usual Residence of Decedent 10c. City, Town or Location 10h Counts 10d. Inside City Limits 10a State 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar mast be notified at Howard Columbia MD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21046 9359 USA Guilford Koad permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene
important: If item 27 is marked other than "natural", or items 23a
any injury or other traumatic event, the Medical Examples reserved. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic 12th grade NA Homemaker 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Be Jackson Edward Snell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ursula T. Parker/Orand Daughter 2248 Countissary Circle Obnton, M) 21113

Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition □ Donation 5 □ Other (Specify) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadownidge 03:02:05 Elkridge 22. Name and oddress of Facility Valuation C. Greene Funeral Services 5151 Baltimore Northmal 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsues of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 ZUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has b autopsy performed? 2/ No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1/ Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification; After 1_Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature in title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42580 02 23 75 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis Rd. #13 Bladensburg MD 20710 P.S. Aulla, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 4 2005

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#

MR

32. Registrar's Signature

_			For State Registrar	State of Maryland / Depa	artment of Health and N rtificate of Death	fental Hygier	/ 11115	07211
	Physici /Medi		1. Decedent's Name (First, Middle, Last) C'LARENCE	HUGHES		February &	Day Yeer	3. Time of Death
	Examir Funeral	ner	4a. Facility Name (If not institution, give si Boy Secours H 5. Social Security Number 6. Sex	reet and number) Spital 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death BO H MOYE If Under 1 Year If Under 24 Hrs.		Ic. County of Death	Naca (State or Foreign
	Director		236.26.4245 132 Usual Residence of Decedent	M 2□F S Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea DT ·) C · M	13	place (State or Foreign
	ith the Marylar or 28a-1 show	ector	10a. State 10b. County 10e. Street and Number	10c. City, Town or Lo	ltimore			0d. Inside City Limits 1 Yes 2 No
	eath with	Funeral Director	827 N. Arlingtor	Avenue	10f. Zip Code 21217		Citizen of What Cour	
920	72 hours after death with the Maryland netural', or Itema 23a or 28a-f show disal Examinar roust be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1⊠Yes 2 □ No	Was Decedent of Hispanic Origin? (Sp. if Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	an Indian, etc. ACK
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or itema 23a or 28a-s show any injury or other traumatic event, the Medical Examinat roust be notified at any injury or other traumatic event, the Medical Examinat roust be notified at any injury.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Inc	dustry
Maryland 2	should be filed nd Mental Hyg marked othe amatic event,	To Be C	17. Father's Name (First, Middle, Last) J. P. Hughes		18. Mother's Name	e (First, Middle, Maide na Mitche		
	1 and 2 sh Health and Iem 27 Is m		19a. Informant's Na a elationship (Typ Karen Waddell) 20a. Method of Disposition	Daughter 43	ng Address (Street and Number or Rura O Miam' Place sition (Name of natory or other place)	e Balti	or Town, State, Zip	21207
altimore,	mit. Pages bartment of ocrtant: If it		1 ☐ Burial 2 DC Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licens	Green	mount 103.	1.05 B		
ä	Deprilipor		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one		remotion Services 151 Baltimore National Research Researc	Tional Pike	Baltimo	MD 21229 Approximate Interval Between
7	Priysician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of): De Mydration Due to (or as a consequence of):	naunthion d		DALFOR	Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
P.O. Box 6	Attending Physicien: The law requires that the death certificate be executed early. The death. ector, their this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-trans.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Y <i>e</i> ar
ords, F	equires tha en signed ould be det	þ	Part II. Other significant conditions cont	ibuting to death but not resulting in the ur	nderlying cause given in Part I.		use contribute to the	e cause of death?
I Reco	iicien: The law r certificate has be rector, page 2 sh	Completed				24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of
Vita	icien: Sertific ector,	Be	25. Was case referred to medical examiner?	spital:	26. Place of Death			
Division of Vital Records,	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	The state of the s	me 5 Residence 28d. Describe how inju)
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, streed building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural e)	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my knowledge, death or: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurred	and due to the cause(sed at the time, date an	s) and manner as stand due to	ited. the cause(s)
	To T com	Σ	29b. Signature and title of certifier R. m. Shah m.		29c. License number D 0 0 9 6 5 8	(Feb) 2	ate signed (Month, D	5.
_	1	21	30. Name and address of person who com	pleted cause of death (Item 23a) (Type, I	HOSPITAL, S	3 altimo	8R. H	0
*	Sta Registr	te ar	31. Date filed (Manth, Pay Year) 2005	32 Registrar's Signature	rele .			

			State of Maryland / Departn		-	_	
		1	, FOI	icate of Death		2005	07212
		74	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Idelia Hardy		February:	Day Year	-7:40 PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b.	. City, Town, or Location of Death		4c. County of Dealf	1/1
	•		Sinal Hospital of Bultimore	Saltmore Cit	Y	1	V/ 71
	Funeral			Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day,)	ear) Coi	nplace (State or Foreign ontry)
i.	Director		Usual Residence of Decedent		05.07.	1925	140
	yland iow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	a-fst	ctor	MD N/A Baltimor	re			1 🔀 Yes 2 🗌 No
	or 28	Funeral Director		Of. Zip Code	100	g. Citizen of What Co	untry?
	ath w	lal	3606 Reisterstown Road	21215		USA	
	ltams	nue	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was If Yes 1 Never Married 2 Married 1 Yes 2 25 No	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5	urs aff	by	If Yes, Give Year or Dates:	Yes 2 No Specify:		Specify: 2	ack
2	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Itams 23a or 28a-f show avent, the Medical Examiner must be notified at		15. Decedent's Education 16a. Decedent's	s Usual Occupation	ing 16	3b. Kind of Business/I	ndustry
į	thin 7	Completed		of work done during most of work	ing	Meta	News
7	led will ygjer than th			'ashier	e (First, Middle, Ma	-	700710
2	be fi	Be	17. Father's Name (First, Middle, Last) Father's Name (First, Middle, Last)	Franci	10. 1	ardson	
Ž	2 should be filed withir and Mental Hygiene. is merked other then sumatic avant, the M.	P P	200.10	ddress (Street and Number or Rura			in Code)
2	and 2 s ealth an n 27 is nar trau		Gleneace Holmes/Daughter 2003	N. Wolfe Stree		more Mi	
ָם ע	f Healitam		20a. Method of Disposition 20b. Place of Disposition	n (Name of		c. Location - City or	
2	Pages nent of int: If it.		1 ⊠Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)		13.05 1	Presville	, MD
<u></u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Itams 23a or 28a-1 show any injury or other traumatic avant, the Medical Examiner must be notified at once.		21. Signalure of Funeral Service Licensee	ime and Address of Facility			,
۵_	80 E 2 8		2 augh (4)				Ore MD 21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	e mode of dying, such as cardiac of	or respiratory arres	it,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	estral cetar	works		Iday
	/Medical Examiner		Due to (or as a consequence of):	1 1.			
	N	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).	Soul Olis	ense		13 years
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
Š	te be executed ysician and ie burial-transit		resulting in death) Last Due to (or as a consequence of):				
000	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Ical	d				
00 X	ertific ling p	Physiclan/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
	attend for us	lan	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ector in the past 12 months?	opic pregnancy ner (specify)		23d. Date of deli Month	Day Year
ċ	the de	ysic	1 Yes 2 No 9 Unknown 9 Unknown				
Ţ	The law requires that the death certilica tte has been signed by the attending ph bage 2 should be detached for use as th	by PI	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
	quire en sig	ed b			1 🗆 Yes	2 □ No 3 □ Pro	obably 4 Minknown
ב ב	law re as be	ompleted			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
_		Com			performe 1 ☐ Yes 2 [ed2/ death?	
110	yaician: The law is certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?		h (Check only one)		
5	S .9	- To	1 ☐ Yes 2 ☐ No		me 5 Residen 28d. Describe how		cify)
5	ng fter	tlon	1 PNatural 5 Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		and the second s	
2	Attan r deal actor: by the	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office	28f. Location (Stre City or Town,	et and Number or Ru	ral Route Number,
5	s afters all Direction	Cert	4 Homicide determined building, etc. (Specify)		ony or rown,		
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investi				
	o the ithin 2 o tha omplei	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	n, Day, Year)
	F 3 F 8			RES-01	00 0	han 2-	2005
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	RES-00			
	Ţ		Edward Radder MD Smail +	tespotal of B	altimo	ع	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 4 2005 33 Registrar's Signature	E CONTRACTOR OF THE PARTY OF TH			

latent Known as

			1 = State Registrar	State of M	aryland		artmeni rtificate			nd Me	ental Hy	giene Reg. No		5	07213
	Physici	an	1. Decedent's Name (First, Middle, Last, Patricia	Ann	Har	ley					2. Date of De Month Februa	Da		Year 005	3. Time of Death 8:11 PM M
	/Medic Examir		4a. Facility Name (If not institution, give Shady Grove Adven	street and number))				Location of		rebrua		. County o	f Death	
	Funeral Director		414-36-1703	x 7. Ag ∃M 2∭2 F	ge (In yrs. Ia 68	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. 8 Min.	B. Date of Bir (Month, Da Nov • 1	th ay, Year) .9,]	1936		ace (State or Foreigr ry) 1essee
	h the Maryland or 28e-f show e rolling at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome 10e. Street and Number		10c. City,	Town or Lo	Rock	Code					tizen of Wi	nat Count	•
9003	72 hours after death with the Maryland naturel', or Items 23a or 28e-1 show died Executes must be notified at	by Funeral	11013 Schuylkill 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 XX If Yes, Give Year or Dates:	?		Was Decedif Yes, special Yes	lent of Hi offy Cuba 2 XX No	Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.)	D-	14. Race Black Specify:	- America , White, e	n Indian, tc. Vhite
Maryland 21215-0036	ad within 72 rgiene. er than "nai t, it e Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	(Give	kind of wor DO NOT us	rk done d	luring most) iry			0	Gover	nment	
yland	12 should be filed within h and Mental Hygiene. 7 is marked other than "treumatic event, the Me.	To Be	17. Father's Name (First, Middle, Last) Walter E.	Fletcl	her	401 44 11			F1o	ssie	First, Middle	0.	As	sher	
Baltimore, Mar	1 and Healt tem 2		19a. Informant's Name/Relationship (T) Kimberly Ahmadi / 20a. Method of Disposition 1 Burial Accremation 3 F 4 Donation 5 Other (Specify)	Daughter	20b. Pla		7 Ivy esition (Nam matory or o	berr	y Way			ry V	/i11a	ge, N	D 20886
Baltin	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Coers		M003	22 R	app F	d Addres	s of Facility	d Cr	ematio er Spr	n Se	ervice		
	Physician /Medical Examiner	miner	23a. Part1. Enter the disease, or compishook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a Due to (or as	une. astati s a conseque pirato	c Bre	ast C	ance		eardiac or	respiratory a	arrest,			Approximate Interval Between Onset and Death years
). Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician end cage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	in the past 12 months? 1 \(\sum \text{Yes} 2\overline{\text{X}}\) No	Due to (or as d	e of pregnan 2 Fetal (icy death 3[⊒Ectopic pr □ Other (sp						23d. Date Mont		y Day Year
rds, P.O	quires that the death n signed by the atte uld be detached for	d by Phys	9□Unknown Part II. Other significant conditions co Obesity		but not resul	lting in the u	inderlying c	ause giv	en in Part I.						cause of death?
of Vital Records,		Completed by									1 ☐ Yes	psy ormed? 2 XX No	pr	ere autop ior to com ath? Yes	sy findings available ipletion of cause of
Division of Vit	F F E	Certification: To Be	25. Was case referred to medical examiner? 1 Yes	28e. Place of Ir	ay Year)	R/Outpatie 28b. Time o Injury	of M	8c. Injun Worl	er: 4 ☐ Nur	sing Hom 28	(Check only e 5 Res d. Describe Bf. Location (City or To	idence how inju	nd Numbe	d	Route Number,
Ö	To the Hospitel or Attending within 24 hours efter death. To the Funeral Director: Attencompletely filled in by the fune		29a. Certifier (Check only 2 Medical Exam	/sician: To the bes	t of my know	vledge, deal	th occurred	at the tin	ne, date and	i place, ar	nd due to the	cause(s	s) and man	ner as sta	ited.
	To the Hospitel within 24 hours. To the Funerel completely filled	Medical	29b. Signature and title of certifier	and manners	D			c. Licens	e number 054299			29d. Da	ate signed	(Month, E	
	Sta	ate	30. Name and address of person who ceric Brodsky M. 31. Date filed (Month, Day, Year)					Dr	Rock	vill	e, MD	20	0850		

			For State Registrar	State of Maryla			of Health and of Death		giene Reg. No. 20 (05 07211		
75	*		Decedent's Name (First, Middle,	Last)				2. Date of De Month	ath Day Ye	3. Time of Death		
	Physici: /Medic		Rudy	HELI	m s			March	3, 2005	4:00 AM M		
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, To	wn, or Location of D	eath	4c. County of D	eath		
			8439 Church Ro				Pasade		Anne A			
	Funeral			M	rs. last birthday 8 Yrs.	Months D		Ain. (Month, Da	y, Year)	Birthplace (State or Foreign Country)		
	Director		214-22-1978 Usual Residence of Decedent		8 113.			02/0	2/1927 M	D		
	land ow	Ì	10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits		
	Mary Fe sh	ţ	MD Anne	Arundel	Pasaden	a				1 ☐ Yes 2 No		
	r 28s	irec	10e. Street and Number			10f. Zip Co	ode		10g. Citizen of What	Country?		
	th wil	aiD	8439 Church Roa	211			United S					
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Modical Examiner must be notified at	Funerai Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent If Yes, specify	t of Hispanic Origin' Cuban, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	Hack, W	rmerican Indian, /hite, etc.		
36	or II	by Fu	1 Never Married 2 Marrie	If Yes, Give	1 ☐ Yes 2 No If Yes, Give Year or Dates:				Specify:			
21215-0036	hours tural	d be	3 ☐ Widowed 4 ☐ Divorced		16a Dece	edent's Usual C	Occupation		16b. Kind of Busine	Nhite ess/Industry		
7	in 72 n" ra	Completed	(Specify only highest	grade completed)	(Give	b kind of work of DO NOT use	done during most of retired)	working	Chemical			
77	iene.	mo	Elementary/Secondary (0-12) 5	College (1-4or 5+)	Firs	st Clas	s Machini	st				
D	illed Hygid other	BeC	17. Father's Name (First, Middle, L	ast)			18. Mother's	Name (First, Middle	Maiden Sumame)			
Maryland	should be nd Mental marked c	To B	Jack Helms				Rebec	ca Smith				
ary	2 should be filed within and Mental Hygiene. Is marked other than aurmatic event, the Mental than the Mental transmitters of the		19a. Informant's Name/Relationsh		19b. Mail	ing Address (S	treet and Number o	r Rural Route Numb	er, City or Town, Stat	e, Zip Code)		
	is 1 and 2 of Health a item 27 is other tra		Randy Helms / Sc					asadena, N				
ore	of He		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation	ł	 b. Place of Disp cemetery, cre 	osition (Name Imatory or othe	of or place)	Date Mar 5	20c. Location - City	or Town, State		
Ĕ	Pag ment ant: I		* 4 □ Donation 5 □ Other (Sp	ecify)			norial Par		Glen Burn	nie, Maryland		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show eny injury or other traumatic event, the Marical Examiner maint be notified at Onca.		21. Signature of Funeral Service L	icensee Mo	288C	Cremati		neral Alter		Maryland 2128		
8760,	Physician /Medical Examiner physician and physician and physician and physician stranger physician are physician and physician are physician and physician are physician and physician are physician and physician are physician are physician are physician and physician are physician a	lical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Security list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or as a con Due to (or as a con Due to (or as a con Due to (or as a con	sequence or):	Infar	etion			Interval Batween Onset and Death		
.O. Box 68	wrequires that the death certificat been signed by the attending phy should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 profiths? 1 Yes 2 No 9 Unknown	23b. Was decedent pregnant In the past 12 pronths? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Elive birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					23d. Date of delivery Month Day			
Δ.	The law requires that the tite has been signed by thouge 2 should be detache	by Ph	Part II. Dther significent condition		d tobacco use contribute to the cause of death?							
ord	nequi	ted				1 - 1						
Records,	e las has	Completed						24a. Was auto perfo	an 245. Were prior deatl			
Vital	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?					Death (Check only	one)			
<u>></u>	ys dilb	To I	1 ☐ Yes 2 No		2 ER/Outpatie		1		dence 6 Other (5	Specify)		
on of	ding Afte fune		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investig		. injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	28d. Describe how injury occurred					
Division		Certification:	3 Suicide 6 Could n 4 Homicide determi		ffice		28f. Location (Street and Number or Rural Ro City or Town, State)					
	Mospital or 24 hours afte Funeral Dir etely filled in	edical (xaminer: On the basis of examiner and manner stated.	occurred at the time,	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. L	icense number		29d. Date signed (M	onth, Day, Year)				
	->-0		D 1/2	350/		(76786		3-5-6	> 5		
	3	:	30. Name and address of person of	the completed cause of death	Item 23a) (Type	Print) Hama	ands the	L-2.	Brooklyn	onth. Day, Year) > 5 PNK, MO		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's 9	gnature	de do	arti	(

			Please Type or Print in Black Indelible Ink. Ensure All	-	_							
			1- State of Maryland / Department of Health and M Certificate of Death		_ ZUII:	07215						
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	J. No.	3. Time of Death						
	Physici /Medio		Odesser B. Hipkins	March	2,200	5 9:00 PM						
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dec	ath A						
	Funeral		1123 W. XT SI 3C Dallimon	8. Date of Birth	/V/ (rthplace (State or Foreign						
	Funeral Director	١,	217-12-9319 1 M 2XF 80 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	(S. 1924 N	aryland						
	and		Usual Residence of Decedent 10a. State 10b. County / 10c. City, Town or Location			10d. Inside City Limits						
	Maryl -1 sho	to	Maryland N/A Baltimore			1 Yes 2 No						
	or 28e	Director	10e. Styleet and Number 10f. Zip Code	100	g. Citizen of What C	ountry?						
	s 23e	eral I	123 W. 29" St. 30 2/2/8		US	SH						
(0	r Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto f	Rican, etc.)	14. Race - Am Black, Whi							
21215-0036	72 hours after death with the Maryland natural; or Items 23e or 28e-1 show uical Examitterust be notified at	d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 No Specify:		Specify: P	lack						
15-(n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired]	ng 16	6b. Kind of Business	/Industry						
212	filed within Hygiene. other then "	duo	Elementary/Secondary (0-12) College (1-4or 5+) Dome Stic Work	cer f	Private	Families						
	be filed trail Hygie od other is event, it	Be	17. Father's Name (First, Middle, Last)	(First, Middle, Ma	iden Sumame)	100111						
Maryland	2 should be and Mental Is marked of sumatic eve	ှင	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ruse)	Jer	nings	>						
			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ruse) Nr Patric K H. Hinkins 140 Relationship	Va Lu	the cuit	Zip Code) 21093						
ore,	ges 1 and 2 t of Health If item 27 or other tro		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	ate 20	c. Location - City or	Town, State						
Baltimore,	Pag nent int: I		'4 Donation 5 Other (Specify) Arbutus Mem. Park 3/8/6	2005	Balto.	Md.						
Bal	permit. Departr Importe eny inju		21. Signature of Funeral Service Licensee	Funera	1 Home							
	Pnysician /Medical Examiner		23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arres	to Md. 2	Approximate Interval Between						
			Immediate Cause (Final disease or condition PATURES OF CONTROL OF	4 Disa	case	Onset and Death						
			Due to (or as a consequence of):									
	115	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	be executed ician and burial-transit	Examiner	that initiated events C.		10							
760,	te be executed ysician and le burial-transit	Due to (or as a consequence of):										
68	The law requires that the death certificate to the has been signed by the attending physicage 2 should be detached for use as the beareness.	Aedic	US SERVICE									
Вох	ath ce ttendir or use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12,months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de Month	,						
o.	at the de by the a tached f	Physician/Medi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 ☐ Other (specify)		World	34, 134						
<u>α</u>	s that gned b	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?						
ord	tw requires that s been signed b should be det	ted	Hyperfersion, Type of Drabettes Mellitus,	1 🗌 Yes	2 □ No 3 P	robably 4 Unknown						
Rec	The law cate has b page 2 st	Completed	Hypercholestellolemia.	24a. Was an autopsy performe	opsy findings available ompletion of cause of							
of Vital Records,		0	25. Was case referred to medical 26. Place of Death	1 Yes 2 2	d? death? No 1 ☐ Yes							
ίV	S S	To B	examiner? 1 Yes No	11	ce 6 Other (Spe	cify)						
	ing ifter ine	lon:	1) Natural 5 ☐ Pending (Month, Day Year) Injury Work?	8d. Describe how	injury occurred							
Division	al or Attending PI s after death. Il Director: After the ed in by the funera	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 2		et and Number or Ru	ural Route Number,						
٥	ital or irs afte rel Dir	Cert	4 ☐ Homicide building, etc. (Specify)	City or Town, State)								
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Mont	h, Day, Year)						
)	Λ-		D 35082		3/4/05	11-20 AM						
	1)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2323 Oulland At, Baltimore, MD 21224									
	t Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature									
	Registr		MAR 0 4 2005 See 16 Acres 16									
DH	MH 17 Rev 1/20	001	ORIGINAL									
DH	,		MAR 0 4 2005 Seem & Joseph ORIGINAL									

			For 1 - State Registrar	State of I	Maryland					and M	lental Hy	0	OOM	n	7216	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death										000	- 0	3. Time of Death	_
	Physic		Frances Hasse	.							Month 02/27	Day	Yea		7:40P M	
	/Medi Examir		4a. Facility Name (If not institution,		er)		4b. City,	Town, or	Location of	of Death	02/27	· -	County of D	eath	7.401	-
1			1561 Colony 1	Drive			Pas	ade	na				nne A		de1	
	Funeral			. Sex 7.	Age (In yrs. la	ast birthday)	If Under	1 Year	If Under:		8. Date of Birti				e (State or Foreign	7
	Director		203-10-7751	1 M 2 M F	81	Yrs.	Months	Days	Hours	Min.	8. Date of Birti (Month, Day 04/15	19	23	Country	MD	
	pu .		Usual Residence of Decedent 10a. State 10b. County		10a Cib	, Town or Lo										_
	sho	2	,											10d.	Inside City Limits 1 ☐ Yes 2 ▼No	
	the N	Director	MD Anne 2	Arundel	Pa	asade										_
	er death with the Marylan Items 23a or 28a-f show at must be notified at						10f. Zip						zen of What	Country	?	
	eath	erai	1561 Colony I		nt Ever in 11 C	2 112 1		122	i- Osi-	-:-2 /0-			S.A.		1.20.	_
40	iter dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 2 Married 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								14. Race - A Black, W					
38	of', or	by F	3 Widowed 4 Divorced Divorced 1 Yes 2 Mo Specify:								Specify:	Whi	+0			
õ	within 72 hours after death with the Maryland ane. then "naturef", or items 23a or 28a-f show the Medical Everthet must be roulified at	To Be Completed	15. Decedent's			16a. Deced	dent's Usua	al Occupa	tion			16b. Kir	Sb. Kind of Business/Industry			
215	hin 7		(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4c	25.54)	(Give life. l	kind of woi DO NOT us	rk done di se retired)	uring most	of worki	ing				,	
21	filed within the thing the the the the the the the the the the		5	College (1-40	7 3 7)	Pr	opri	etoi	r			Res	staur	ant		
p	be filed within 72 ha (al Hygiene d other then "nature) event, the Medical		17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)			_
la			John Wujcik						An	iela	a Male	2				
Maryland 21215-0036	and and is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Rura	l Route Number	r, City or	Town, State	, Zip Co	ide)	_
	1 and Health Iem 27 other tr		Vicky Dicksor	n/Daughte		-law	156	1 Cc	olon	y Di	cive, 1	Pasa	adena	, M	D 21122	
ore	S to = 0		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	□Removal from Sta		ace of Dispo metery, cren	sition (Nan	ne of					cation - City			_
Ĕ	Pages ment of ent: If Its ury or o		`4 □Donation 5 □Other (Spec		" Gl∈	en Ha	ven	Mem	Pk (03/0	03/05	Gler	Bur	nie	, MD	
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lic	ensee		22	. Name an	d Address	of Facility	/ G. J	J.Gonce	e Fi	nera	1 H	ome, PA	_
ш			Jen /E	0-		1	69 R	ivie	era 1	Driv	re, Pas	sade	ena,	MD	21122	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between													
	Physician		Immediate Cause (Final disease or condition Onset and Death													
	/Medical Examiner		resulting in death)	Due to (or a	as a conseque	ence of):	0							1		_
и	LAGIIIIICI	_	Sequentially list conditions,	b												
_	be sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
	and and I-tran	Examin	that initiated events resulting in death) Last Due to (or as a consequence of):													
8760,	death certificate be executed e attending physician and od for use as the buriat-transit															
87	phys the	dicai	•	d										-		_
9 x	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcom	a of pregnan	CV										_
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 menths?	1 ☐ Live birth	2 Fetal of at time of dea	death 3 [Ectopic pre					2:	3d. Date of d Month	elivery Day	y Year	
o.	e the	ysic	1 Yes 2 No 9 Unknown	9☐ Unknown		am 5∟	Other (spe	эспу)							, , , , , ,	
٥			Part II. Other significant conditions	contributing to death	but not result	ting in the ur	derlying ca	use giver	n in Part I.		23e. Did tob	pacco us	e contribute	to the ca	ause of death?	_
Records,	ed be	d by	Multi infanct	demen	ha		,,,,,				1 □ Ye		,	Probably		
Ö		Completed	Clarty '9 is	dille	. 0, 0	R Q-										_
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		e Co	high wood an	12 hour							1 ☐ Yes 2	200	1 □ Ye] No	_
Vital	Physician: this certific ral director,	8	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:		510		Other			(Check only on					_
		. To	1 Yes 2 No 27. Manner of Death	1 □ Inpa		R/Outpatient 28b. Time of		A Bc. Injury a	4 🔲 Nur		ne 5 Reside 8d. Describe ho		Other (Sp	ecify)		_
o	iding Ph th.: After th funeral	Certification:	1 Natural 5 Pending investigati	28a. Date of In (Month, E	Day Year)	Injury	М	Work?	ns 2 □ N			in anjury	00001100			
Division	l or Attending after death. Director: After I in by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. I							28f. Location (Street and Number or Rural Route Number,					_	
á	i giệ c	erti	4 Homicide building, etc. (Specify)													
	Hospital or 24 hours afte Funeral Dir tely filled in t		29a. Certifier 15 Certifying F	hysician: To the bes	st of my knowl	ledge, death	occurred a	t the time	, date and	place, a	nd due to the ca	use(s) a	nd manner a	s stated	t	_
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Exa	aminer: On the basis and manner:	of examination	on and/or inv	estigation,	in my opir	nion, death	occurre	d at the time, da	ate and p	lace, and du	e to the	cause(s)	
	To the To the Complet	M	29b. Signature and title of certifier	. (1			29c.	License	number		29	d. Date	signed (Mor	nth, Day,	Year)	-
			* Mulain m	1000	u n	m	1)210	013			2/2	8/nc	_		
	12		30. Name and address of person who	completed cause of	death (Item(2	23a) (Type, F	Print)	4				14	104	6	PASANCIA	_
_	10		LOKATLEF M.	DAILE	1 ML) B(296	EX	NIC	JR	AYLLOR	B	VOX	Sie	MO	l
	Sta	te	31. Date filed (Month, Day, Year)	32. Aligis	trar's Signatur	K A	rade	,	_ =	•	, ,					_
	Registr	ar	MAR 0 4	2005	ener 1	- 19	A.F. 10 TO TO									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene
Registra AMEND ITEM #5 PER FH G841 3/08/09/39 of Death
Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** ohn 11:30 D M e billary 26, 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bon Secours Hospital Baltimore Baltimore City 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 12/04/1920 South Carolina **Funeral** 7. Age (In yrs. last birthday) Months Days Hours Yrs Director 84 220-03-3383 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f ehov treumatic event, the Medical Exeminer must be notified at Yes 2 No Director Baltimore City Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 2502 Francis Street 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1∑Xes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 Yes Z No Specify Specify: Black þ 3 Widowed 4 Divorced Year or Dates:WW T T neture Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tent: If item 27 is marked other th jury or other treumatic event, Its Truck Driver Davidson Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John W. Hartfield, Sr. Seppie E. Hartfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thione Smith Hartfield 2502 Francis Street-Baltimore, Md. 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3-8-05 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o importent: If eny injury or once. 4 Donation 5 Other (Specify) Garrison Forest Cem03/3/2005Owings Mills, Md. 22. Name and Address of FacilitEstep Brothers Funeral Serv. 21. Signature of Funeral Service Licenses 1300 Eutaw Place, Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** phumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2□ No 1 Yes 2 No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Yes 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification; 28d. Describe how injury occurred After 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funerel [29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 45148 lbruary

State Registrar icardo

31. Date filed (Month, Day, Year)

Sorno

IAR 0 4 2005 Steem & Goods

32. Registrar's Signature

Hospital

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

) ecturs

2000 West Baltimore Street,

			1 - State of Maryland State of Maryland	l / Depa <i>Cei</i>	artment of Health and I rtificate of Death	Mental Hygie Reg.	ne2005 0	7218							
	Physicia	20	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	ime of Death							
	/Medic		Vivian J. Hughes			February	27, 2005 2	:25 P M							
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	י	4c. County of Death								
	Funeral		Somerford Place 5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	Annapolis If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Arundel 9. Birthplace (S	State or Foreign							
	Director		558–18–3412 1□M XXF 82	Yrs.	Months Days Hours Min.	(Month, Day, Ye 9-12-192)	ar) 9. Birthplace (S Country) Califor	nia							
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City.	Town or Lo	cation			ide City Limits							
	Maryla f sho	ō			Marlboro			Yes 2 No							
	r 28a-	rec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?								
	th with	Funeral Director	13507 Vandiver Ct.		20774	1	JSA								
	ems	ıner	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	13.	Was Decedent of Hispanic Origin? (Sf Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indi Black, White, etc.	ian,							
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is merked other than "natural, or Items 23a or 28a-f show or other traumatic event, Ite Medical Evanture must be notified at	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 🕅 No 1 ☐ Yes, Give 3 🛣 Widowed 4 □ Divorced Year or Dates:		1 □ Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: White								
21215-0036	2 hour		15. Decedent's Education	16a. Dece	dent's Usual Occupation	166	. Kind of Business/Industry								
215	within 72 ene. than "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. i	kind of work done during most of wor DO NOT use retired)	rking	,								
	e filed within al Hygiene. I other than ' vent, I's I's	Con	12th	Но	memaker		Home								
Maryland	be fill ad oth even	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	den Sumame)								
Ž	2 should be and Mental is marked craumatic even	은	Joseph Maurice Chirhart 19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru	oel Holman	tv or Town State Zin Code)								
	and 2 sealth ar n 27 is ser trau		Jo Ann Chalker/ Daughter		7 Vandiver Ct., U										
Jre,	es 1 and 2 of Health I Item 27 i r other tra		200	ace of Dispo	sition (Name of natory or other place)		. Location - City or Town, St								
<u>E</u>	Pages ment of ant: If It ury or o		I Burlar 2 Licremation 3 Linemoval from State		ematory 3-1-	-05 Ec	gewater, MD								
Baltimore,	permit. Pages Department of Important: If I any injury or one		21. Signate of Funeral Service Licensee			eorge P. Ka	alas Funeral								
	-		23a. Part 1. Enter the disease, or complications that caused the death.	2973 Solomons Island Rd. Edgewater, MD 21037 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate											
	Pnysician		shock, or heart failure. List only one cause on each line. Interval Between onediate Cause (Final base or condition												
	/Medical Examiner		resulting in death) a Due to (or as a consequence)	ence of):											
	Lammer	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequent to the control of the	anna of\:											
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Вох	leath certifi attending I I for use as	lan/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of	death 3□	Ectopic pregnancy		23d. Date of delivery Month Day	Year							
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of Vital Records,	w requires been sign should be		failure to thrine			1 🗆 Yes	2 No 3 Probably	4 Unknown							
000	law as b	ompieted				24a. Was an autopsy	24b. Were autopsy find prior to completio	dings available							
Ä	The ate h page	Com				performed	? death?								
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		Other	ath (Check only one)	1	Ser Ver							
of	Phys this ral dir	L.	1 Tes 2010 1 Inpatient 2 E	R/Outpatier 28b. Time of	,	lome 5 Residence 28d. Describe how i		t w							
ion	Attending Ph r death. ector: Atter th by the funeral	tion	1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	2007 2000 11017	ijaly oddanod								
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Ö	ital or A	O	building, etc. (opposity)		•	0.19 01 10 1111, 31									
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edicai	29a. Certifier (Check only one) Physician: To the best of my know and manner stated.	riedge, deati on and/or in	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the ca	use(s)							
	To the within 2 To the complet	ž	29b. Signature and little of certifier		29c. License number	29d.	Date signed (Month, Day, Ye	ear)							
•	i				D5702	8 2	2.28.05	_							
	6		30. Name and address of person who completed cause of death (Item :	23а) (Туре,	Print)	Z1 D	2.28.05 pells,MD.7	27.70							
	Sta	ate.	31. Date filed (Month, Pay, Year) 4, 2005 32. Registrar's Signatu	UKIC	IGALIAN. STIZ	or Hina	pous, 1110.2	1401							
	Regist		MAR U 2 2005	B. A	mente										

		1 - For State Registrar	State	of Maryla			ent of H ate of L				iene	005	07219
Physic		1. Decedent's Name (First, Midd	e, Last) Elaine So	chneide	r Hain	es			N .	Date of Deat Month bruar		2005	3. Time of Death 8:00 A M
/Med Exami		4a. Facility Name (If not institution	n, give street and n	umber)		4b. C	ity, Town, or	Location of				nty of Death	3.00
		Layhill Center,	Genesis	Elderca	re	Si	llver	Sprin	ıg		Mont	gomer	У
Funeral Director		5. Social Security Number 100–16–6454	6. Sex 1 ☐ M 2K F	7. Age (In yrs	s. last birthda Yrs.	y) If Ur Mont	hs Days	If Under Hours	24 Hrs. 8. D Min. (/ Ma	Date of Birth Month, Day, Y 4,	1923	9. Birthp Cour New	place (State or Foreign ntry) York
and	7	Usual Residence of Decedent 10a. State 10b. County	,	10c. C	ity, Town or	Location							10d. Inside City Limits
Maryl f sho	ō		omery		Silve		rino						1 ☐ Yes 2 🐴 No
r 28a	Directo	10e. Street and Number	omery				Zip Code			1	0g. Citizen o	of What Cour	ntry?
th with	ai D	3227 Bel Pre	Road				2090	6		U	nited	State	S
and Z I Z I 3-UU30 be filed within 72 hours efter death with the Maryland hall Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Evertires must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	ned 1 Tyes	2⊠No Sive	U.S. 1:		ecedent of Hi specify Cuba s 28 No	spanic Orig n, Mexican Specify:	gin? (Specify n, Puerto Ricar	Yes or No- n, etc.)		lace - Americ lack, White,	etc.
5-UUSO 72 hours of natural', or	ed b		Year or	Dates:	16a Dec	adent's I	Jsual Occupa	ation			16h Kind of	Whi	
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and dbe file antal Hy ced oth c event	Be	17. Father's Name (First, Middle,							er's Name (Firs		Maiden Sum	ame)	
ABLYIBING 2 should be f 3 and Mental 8 1s marked of raumatic eve	ို	Arthur J. Sch							na M. H				
Mar d 2 sh th and th and traum traum		19a. Informant's Name/Relations		1.					er or Rural Rou				
1 and 1 and		Christopher Sch	neider/Ne		Place of Dis	nosition /	Name of		Flora			√ 10°K n - City or To	
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta important: if item 27 is marked any injury or other traumatic av gones.		1 ☐ Burial 2 ☑ Cremation 1 ☐ Donation 5 ☐ Other (5	Specify)	n State Mo	cemetery, c ntgome emator	ematory ry ium.	or other place Inc.	İ	March 2		Bethes	sda, M	aryland
Dermi Depa impo any i			2	мос	0198 7	Robe	rt A.	Pumph	rey Fu	neral	Home/	Cha	sda-Chevy se. Inc. 3501
		23a. Part1. Enter the disease, o	r complications that	caused the dea	ath. Do not e	nter the r	ISCONS	g, such as	cardiac or res	nesda piratory arre	• MD Z	0814-	Approximate
Physician		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h art failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Atherosclerotic Coronary Artery Disease											
/Medical		resulting in death) Due to (or as a consequence of):											
Examiner		Sequentially list conditions,	b	,									
led isit	nine	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to	o (or as a conse	equence of):								
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Ords, P.O. BOX of requires that the death certific een signed by the attending p nould be detached for use es?	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐ Live	utcome of pregr birth 2 □ Fe gnant at time of nown	tal death	□Ectopi □ Other	c pregnancy (specify)					Date of delive Month	ery Day Year
COTAS, F.C. **requires that the deben signed by the should be detached.		Part II. Other significant conditi	ons contributing to	death but not re	sulting in the	underlyir	ig cause give	en in Part I.	. .	23e. Did tob	acco use co	ontribute to th	ne cause of death?
VII.al KECOTAS, ician: The taw requires to certificate hes been signe ector, page 2 should be	d by	Peripheral Va	scular Di	sease						1 🗌 Ye	s 2 🗆 No	3 ⊠ Prob	ably 4 Unknown
taw rec	Completed	Chronic Anemi	a						- 2	24a. Was ar		. Were auto	psy findings available
The tay	E									autopsy perform I 🗀 Yes 2	/	prior to cor death?	mpletion of cause of 2□ No
VICAL F ticlan: The certificate rector, pag	Be C	25. Was case referred to medica examiner?	ıl					26. Place	of Death (Chi				2 140
hys hys	10	1 ☐ Yes 2 🔀 No	Hospital: 1	Inpatient 2[☐ ER/Outpat	ent 3	DOA Othe	er: 4 🔯 Nu	ırsing Home	5 🗌 Reside	nce 6 🗆 O	ther (Specify	y)
on or vita ding Physiclan; h. After this certific funeral director,	OD:	27. Manner of Death 1 ☑Natural 5 ☐ Pendi		e of Injury onth, Day Year)	28b. Time Injury		28c. Injury Work			Describe ho	w injury occ	urred	
DIVISION I or Attending efter death. Director: Afte	cati	2 Accident invest	not be	AA		М		res 2□1					
Olv Olrection by	Certification:	4 Homicide determ	nined 286. Plac buil	ce of Injury - At ding, etc. <i>(Spe</i> c	nome, rarm,	street, rac	tory, office			ocation (Sti City or Town		nber or Hura	l Route Number,
DIVISION C To the Hospital or Attending Pr within 24 hours effer death. To the Funeral Director: Affer it completely filled in by the funera	edical C	29a. Certifier 1 Certifyi (Check only one)	ng Physicien: To the	ne best of my kr basis of examir nner stated.	nowledge, de nation and/or	ath occur investigat	red at the tim	e, date and	d place, and d	lue to the ca	use(s) and r	manner as st	tated. the cause(s)
o the ithin of the omple	Mec	29b. Signature and title of certific		Tiller stated.)		29c. License	number		29	d. Date sign	ned (Month,	Day, Year)
F 5 F 0		> /º//	1) 1			1	D5:	2261			Fehru	arv 28	3, 2005
0		30. Name and address of person	who completed car	use of death (Ite	em 23a) (Typ	e, Print)					TEDIU	ary 20	29 4003
- D.		Alan R. Segal,		17 Hugo	, .		ilver	Spri	ng, Mar	ryland	2090	6	
	ate	31. Date filed (Month, Day, Year	32.	Registrar's Sign	nature								
Regist	- 4	MAR 0	E 2005	lescon	K.	had							
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** arrumai Feb 24th, 2005 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sal himou N/A omwell NUrsin. H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 14, 1939 # Under 1 Year 5. Social Security Number In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 → M 2 □ F Yrs MD. 216-36-5711 Director 65 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Manyland Depertment of Health end Mentel Hygiene. Important: if frem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must he maintains. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director MD. BALTIMORE DUNDALK 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 60 BROADSHIP ROAD 21222 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Y Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: WHITE Be Completed by 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRAFFIC SIGNAL INSTALLER BALTIMORE COUNTY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CONSTANCE PREVOST EARL HARRYMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA HARRYMAN/DAUGHTER 60 BROADSHIP ROAD, DUNDALK, MARYLAND 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State DRUID RIDGE CEMETERY 3/1/05 PIKESVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 Nans 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or deart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner ettending physicien end for use es the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 € Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Natural

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. : After this funerel efter death.

altimore, Maryland 21215-0020

i Director: A

To the

Certification: within 24 hours e To the Funeral C completely filled Medical

31. Date (Jed Month, Day, Year) State Registrar

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 \ Homicide

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

-uce

2005

6 Could not be determined

MAR 04

rsop who completed cause of death (Item 23a) (Type, Print)

560 32. Registrar's Signature

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of	Marylan		artment of		and Mer	ntal Hygie	2005	07221
	hysicia		1. Decedent's Name (First, Middle,	Lasi)				, Boain	1	Date of Death	Day Year	3. Time of Death 8/12/3/A M
	/Medic xamin		4a. Facility Name (If not Institution,	give street and numb	er)		4b. City, Towr	n, or Location o		e or one	4c. County of Dea	
				RY LAND M.			BA If Under 1 Ye	LT Me	/		N/A	
	neral ector		5. Social Security Number 211 -24 - 7182 Usual Residence of Decedent	1□ M 2 F	Age (In yrs. I	Yrs.	Months Day		Min. 8.	Date of Birth (Month, Day, Ye	par) 9. Bill	rthplace (State or Foreign ountry)
yland	4		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
ne Mai	e notified at	Director	MD Bart	more	P	erryv	rlle;	MD				1 ☐ Yes 2 No
tiled within 72 hours after death with the Maryland Maryl	importent: It tem 4 / 18 marked other man instudet, or tems 459 or 4584 minor any njury or other treumatic event, <u>the Medical Examinar must be notified at once.</u>	Dire	10e. Street and Number	erd Dru	.10	•	10f. Zip Code	2190	7	10g.	Citizen of What C	ountry?
death	LUMB	Funeral	307 COYIC	12. Was Decede	ent Ever in U.	S. 13. \	Was Decedent of Yes, specify C		32.	Yes or No-	14. Race - Am	
s after	a dina		1 Never Married 2 Marrie	d 1 Tes 2	No	1	rYes, specify C		, Риепо Ніс	an, etc.)	Black, Whi	ite, etc.
hour	Sales Sales	Completed by	3 Widowed 4 Divorced 15. Decedent's	Year or Date	es:		lent's Usual Oc			161	. Kind of Business	Unite.
thin 72	Medis	plet	(Specify only highest Elementary/Secondary (0-12)		or 5+)	(Give life. L	kind of work do DO NOT use ret	ne during most ired)	of working	100	. Ning of Dusiness	unidustry
lygien	it, Early			3*	,	13	certe				Bar	
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should be	umatle umatle	은	19a. Informant's Name/Relationshi	p'(Type, Print)		19b. Mailin	g Address (Stre				ty or Town, State,	Zip Code)
and 2	er tre		Delores Fi	elds		701 1	Broads	street	-		MD 219	
Pages 1	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from Str	ate a C	emetery, cren	sition (Name of natory or other p	olace)	Date	-	. Location - City or	
Dantill Pages Department of	njury		* 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Li		Me	tro C	remat	ory in	Mar 10	105 B	alternore	M0 3
permit. Departm	any c			Grayon	m	17	wale	O F	una	Fune	as mel 2	1201
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acuted	transit	Examiner	Cause (Disease or injury that initiated events	c								
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ficate	as the	edical		d								
th cert	attending pr	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pregna	ncv			23d. Date of de	,
The law requires that the death certific	should be detached for use	Physician/Me	in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown		t at time of de		Other (specify)		<u> </u>		Month	Day Year
that th	detac	by Ph	Part II. Other significant condition	s contributing to deal	th but not resu	ulting in the ur	nderlying cause	given in Part I.		23e. Did tobacc	co use contribute t	o the cause of death?
v requires	onld be									1 🗆 Yes	2 □ No 3 □ P	robabiy 4 Minknown
taw re	as be	ompleted								24a. Was an autopsy	prior to	utopsy findings available completion of cause of
	r, pag	O								performed 1□ Yes 2		3 2 □ No
VII.	s certil lirecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 XInp	atient 2 🗆	ER/Outpatien	t 3 DOA			heck only one)	e 6 □Other (Spe	
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or Attending after death.	the fu	catle	2 Accident investiga 3 Suicide 6 Could no	ition			M 1	☐Yes 2☐N				
el or At	i Director: After this certificate has ed in by the funeral director, page 2	Certification:	4 Homicide determin	and 286. Place of	Injury - At ho , etc. <i>(Specif</i> y	ome, farm, stro	eet, factory, offic	ce .	28f.	Location (Street City or Town, St	t and Number or R tate)	ural Route Number,
DIVISION OI VIIA To the Hospitel or Attending Physicien: within 24 hours after death	lo the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the be xaminer: On the basi and manner	is of examinat	wledge, death tion and/or inv	occurred at the restigation, in m	time, date and y opinion, deat	d place, and h occurred a	due to the cause at the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
To the within	com	Š	29b. Signature and title of certifier	Dul	1-1-			ense number		1	Date signed (Moni	
/	h		Juna	IN JU	wil	7		15231		F	ebiony i	n, wes
			30. Name and address of person w	105 22	So ofh	Grev :	ST BA	MARINE	e m	spyese	0 212	1
R C	Sta Registr		31. Date filed (Month, Day, Year)	2005	istrar's Signa	ture do	and !					

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			Registrar				Ce	rtificat	e of l	Death			Reg. No.	205	07222
	Physici /Medi		1. Decedent's Name (First, RUTH E. KI									2. Date of De Month MARCH	Day	Year	3. Time of Death -
	Examir	ner	4a. Facility Name (If not inst							Location	of Death			unty of Death	
			HART HOME A: 5. Social Security Number	SSISTE 6. Sex			s. last birthday)	If Under		If Under	24 Hrs	9 Data of Bis		TIMOR	
	Funeral Director		212-32-0728 Usual Residence of Decede	1 🗆	M 2XXXF	89	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 10/28/	1915	PENN	nplace (State or Foreigr untry) NSYLVANIA
	ryland how		10a. State 10b. C		-	10c.	City, Town or Lo	cation							10d. Inside City Limits
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Ş	2 hou eture cel E	ted	15. Dec	edent's Educ	ation		16a. Dece	dent's Usua	I Occupa	ition			16b. Kind	of Business/l	
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	To the Hospitel within 24 hours a To the Funerel C completely filled	a C	29a. Certifier 1 2 Cer	tifying Physi	cian: To the b	est of my k	nowledge, death	occurred a	at the time	e, date an	d place, a	and due to the	cause(s) and	manner as	stated.
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	or with	Σ	29b. Signature and title of co	entitier	11	ann		29c.	License	number	01	, '	29d. Date sig	ned (Month,	Day, Year)
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 07223 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Elizabeth Rita Krebs **Physician** Month February 28, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Martin's Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day 7 (947) March 7, 1910 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 94 Months Days Hours 1 ☐ M 2X F 213-34-6083 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intem 27 is marked other than "natural", or items 23s or 28s-f ehow 10a, State 10b. County 10c. City, Town or Location item 27 is markad othar than "natural", or items 23a or 28a-f ehow othar traumatic event, the Modical Exantrer rout be notified at 10d. Inside City Limits Maryland Baltimore Director Catonsville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Maiden Choice Lane 21228 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: þ 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Compl Elementary/Secondary (0-12) College (1-4or 5+) machine operator 6 envelope 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George F. Smith Elizabeth C. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or othar trau QDC®. William C. Wernig, Jr. - son 222 Holy Cross Road, P.O. Box 54, Street, MD 21154 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ` 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery 3/4/2005 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc, 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of Examiner Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ension 1 Yes 2 No 3 Probably 4 Unknown Completed cardio Cascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 2 🗆 No 1 Yes 2 No 1 Tyes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 PNatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor the Funeral Dirac. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I complet the 29d. Date signed (Month, Day, Year)
March 1, 2005 29b. Signature and title of certified 121649 3455 WILKENS AVE. BALTIMORE. MD21229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASKARAN 32. Registrar's Signature Registrar

			Registrar					Cer	tificat	e of	Death			Reg. No	э.		
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	r dea	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No to Rican, etc.)		ce - Americ	
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ord	w require been si should I							1 🗆 \	∕es 2□No	3 Prob	pably 4 Unknown
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	14		30. Name and address of person who co	empleted cause of death	(Item 23a) (Type,		a .		_		1 01001
	Q'		-0 10 07 00 0	G MD		111 Pe	enn Stree	et Baltin	nore, Ma	ırylar	nd 21201
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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P. Div	/Medi	al .	Barbara At					4b. City, Town, or	O2 Location of Dea	25, 20	005	8:00 PM
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	filed within 72 hours efter death with the Marylend Hyglene. ther than "naturel", or flems 23a or 28e-f show int, I'm Medical Examiner must be notified at	To Be Completed by Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Countr	y?
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	ter dea	Š	11. Marital Status	12. Was Decedent Armed Forces?		J,S. 13. Was	s Decedent of I es, specify Cub	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or N rto Rican, etc.)	o- 14. Rad Bla	e - America ck, White, et	
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Maryland 21215-0020		o Be	Theodore Staab						,		10)	
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o	g Phys er this seral d		27. Manner of Death	28a. Date of Inju		28b. Time of Injury	28c. Inju		7	how injury occur	(//	
Sio	Attending Physician: or death. sctor: After this certific by the funeral director,	atlo	1) Natural 5 Pending 2 Accident investigation		roar)			Yes 2□No				
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ury - At h	ome, farm, street, (y)	factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural F	loute Number,
	pottal ours oeral filled	20	29a. Certifier 1X Certifying Ph	/sician: To the best of	of my kno	wiedge, death oc	curred at the tir	me date and place	and due to the	cause(s) and ma	nner as stat	ad .
	To the Hospital or Attendin within 24 hours effer death. To the Funeral Director: Aff completely filled in by the fun	edical		Iner: On the basis of and menner sta	examina	tion end/or invest	igation, in my o	ppinion, death occu	rred at the time,	date and place,	and due to th	ne cause(s)
	vith To t		29b. Signature and title of certifier				29c. Licens			29d. Date signer	d (Month, Da	y, Year)
	.Ú						NO	053414		3/3/	05	
	N		30. Name end address of person who o	Sompleted cause of d	eath (Iten	n 23a) (Type, Prin	(t) E	ne #20	6 12	U, non	MD.	7 17 77
	Sta	te	31. Dete filed (Month, Day, Year)	2005 ^{32. Region}	es Signa	ature /	34	77		-1144.04		
	Registr	ar	MARVE			•						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death FEBRUARY **Physician** 28, 2005 Ø3:48 ₽ M JOHN WILLIAM LAUFERT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Towson ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/20/1928 5. Social Security Number 6 Sax 7 Age (In vrs last birthday). 9. Birthplace (State or Foreign **Funeral** Months Days Hours MARYLAND XXM 2□F Yrs. 219-22-1910 76 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28e-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21234 USA or Items 23a 8127 RIDGLEY OAK ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or DatesKOREA Specify: Completed by Specify: WHITE 3 Widowed 4 Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 YEAR (1-4or 5+) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) PATROLMAN LAW ENFORCEMENT 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit.
Department of Health and Mentat Hy
Importent: If item 27 is marked other
any injury or other treumatic event. 17. Father's Name (First, Middle, Last) Be JOHN LAUFERT MARGARET PROFIT ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARIE HELEN LAUFERT/WIFE 8127 RIDGELY OAK ROAD PARKVILLE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 3/4/2005 MORELAND MEM. PARK HILLENDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses lea 8521 LOCH RAVEN ELVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a.RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ACUTE PULMONARY EDEMA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed as the burial-transit THE MYDCARDIAL INFARCTION that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical RENAL FAILURE IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably CHRONIC OBSTRUCTIVE PULMONARY DISEASE Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an GASTRO-INTESTINAL BLEED certificate has autopsy performed 1 ☐ Yes 2 No COAGULOPATHY Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 XInpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DQA Inis Date of Injury (Month, Day 27. Magner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Year) 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 2-28-05 D 31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar Signature

DHMH 17 Rev 1/2001

State

Registrar

2005

05-153							
	RT J LI	[VI	NGSTON, JR Please	Type or Print in Blac	ck Indelible Ink. Ensure A	II Copies Ar	e Legible.
WHM			Amend it	enstate of Maryland	ck Indelible Ink. Ensure A Department of Health and I	v enga 95vater	ne
			1- State Registrar Unpend Ite:	m 23a&27 per meG8	342 ertificate of Death 4-1	8-05 taskeg. 1	2115 17228
			1. Decedent's Name (First, Middle, La	st). Gilbert J.	Livingston	2. Date of Death	3. Time of Death
	Physici /Medio		Gilbert J.	LivingStor	-Jr.	FEBRUARY	28, 2005 5:45 P M
	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	1	4c. County of Death
20			ST AGNES HOSPITA 5. 22. 7.61.68 6.8		BALTIMORE CITY oirthday) If Under 1 Year If Under 24 Hrs.		NIA
2	Funeral Director		5. SARAMSHUDY TO ILEO	Sex 7. Age (In yrs. last to	Yrs. Month's Days Hours Min.	8. Date of Birth Month, Day, Yea	
4)			Usual Residence of Decedent			May 15, 2	004 Marylana
	show	_	10a. State 10b. County	10c. City, To	wn or Location		10d. Inside City Limits
	889-f	Director	Maryland N	A 180	Utimore		1 PYes 2 No
	death with the Maryland ms 23e or 28e-f show	Di	10e. Street and Number	wood Air	10f. Zip Code	10g. (Citizen of What Country?
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,
	or Iter		1 Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
93	72 hours efter neturel', or Ite	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Black
5-6	"netu	Completed	15. Decedent's E (Specify only highest gr	ducation 16 ade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	king 16b.	Kind of Business/Industry
12	within ene.	d mc	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		Λ/I A
9	filed Hygi other ent, I		17. Father's Name (First, Middle, Last	, 14/1	18. Mother's Nan	ne (First, Middle, Maid	en Sumame)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygiene. Importents if Item 27 Is marked other than "neturel", or Items 23e or 28e-f show amy injury or other treumetic event, Ite Marical Examinational be notified an any injury or other treumetic event, Ite Marical Examinational be notified an once.	To Be	Gilbert J. L	ivingston	Mor	vland	Johnson
ary	and N and N s ma	Г	19a. Informant's Name/Relationship	Type, Print) (Father) 19	b. Mailing Address (Street and Number or Ru	I Route Number, City	y or Town, State, Zip Code)
	and 2 ealth m 27 I		Mr. Gilbert Li	vingston 6	203 N. Ellwood	St. Bal	to.Md, 21224
ore	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		of Disposition (Name of ery, crematory or other place)	Date 20c.	Location - City or Town, State
	t Partmen		*4 Donation 5 Other (Speci	(y) VOS	hell Mem. Gardens	1/2005 D	undalk, Md.
Bal	permit. Departi Importi any inj		21. Signature of Funeral Service Lice	nsee y y	Joseph L. Russ.	Funeral	Home -
			23a. Parti. Enter the disease, or com	aplications that caused the death. Do	o not enter the mode of dying, such as cardiac	or respiratory arrest.	Approximate
	Physician		Immediate Cause (Final			, , , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence	Of Prematurity		
	Examiner		Sequentially list conditions,	b			
	sit ad	amlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):		
	xecuted and Il-transit	Exan	that initiated events resulting in death) Last	c. Due to (or as a consequenc	e of):		
68760,	leath certificate be exe attending physicien ar I for use as the burial-t						
289	requires that the death certificate een signed by the attending physi nould be detached for use as the	Physician/Medical		_ d.			
Вох	n cert anding use a	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 2005		23d. Date of delivery
8	death	sicia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4 Pregnant at time of death	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.O.	that the de ted by the a detached f	Phy	9 Unknown				
Ś	res that signed to be deta	by	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 MUnknown
500		Completed					
Зес	The law ate has b	Id m				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
<u></u>			25. Was case referred to medical		20.51 /5	1 Yes 2□1	
<u> </u>	Physicien: this certific al director,	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 XER/0	0.0	ome 5 Residence	6 Other (Specify)
0		n: T	27. Manner of Death		. Time of 28c. Injury at Injury Work?	28d. Describe how in	
io	Attending F r death. sctor: After by the funer	atlo	1 Natural 5 Pending 2 Accident Investigation	en .	M 1 Yes 2 No		
Division of Vital Records,	or Attendenter de Sirecto	Certification:	3 Suicide 6 Could not to determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
٥	To the Hospitel or Attend within 24 hours after death To the Funerel Director:		CO- Continu				
	Hos 24 ho Fun stely f	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the best of my knowled miner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
	within 2	Me	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)
			I him his,	m.D	OCME	MA	RCH 1, 2005
Pa	removed		30. Name and address of person who	completed cause of death (Item 23a	(Type, Print)	. P.3.	W 1 1 01 001
$\langle \gamma \rangle$	bki		LING LI.	MID	III Penn Stree	t Baltimo	re, Maryland 21201
9		ate	31. Date filed (Month, Day, Year) MAR 0 4 2005	32. Registrare Signat			
	Regist	rar	MAK 0 4 2003	Jones .			

			For State	State of Maryland	/ Depa	artment of H	lealth and M	-	•	07220
			1 - State Registrar		Cer	tificate of	Death		g. No.	01223
	Physici	ian	Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	Ronald Edwin 4a. Facility Name (If not institution, give s			dh O'r T		March	4 2005	12:31A M
	Examin	ner		·			Location of Death		4c. County of Death	
	Funeral		1412 Harberson Ro		st birthday)	If Under 1 Year	iew Park If Under 24 Hrs.	8. Date of Birth	Baltimor	e place (State or Foreign atry)
ם	Director		219-10-5905	M 2□F 79	Yrs.	Months Days	Hours Min.	(Month, Day, Aug. 31,	Year) Cour 1925 West	Virginia
yland	Mou		10a. State 10b. County	10c. City,	Town or Lo	cation			1	0d. Inside City Limits
Mar	le 1-9	to	Maryland Baltimor	e t	Westvi	.ew Park				1 ☐ Yes 2 No
th th	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?
ath w	23a ust b	rai	1412 Harberson	Road		21228			U.S.A.	
er de	Iteme	nue		12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
rs aft	I. or	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 No. If Yes, Give WW I Year or Dates:	I	☐ Yes 21 No	Specify:		Specify: Whi	to
LICE 21213-0030 be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Iteme 23a or 28e-f show any injury or other treumatic event, the Madical Examiner: sast by notified at once.	ted	15. Decedent's Educ	eation	16a. Deced	lent's Usual Occup	ation	10	6b. Kind of Business/In	
hin 7:	N P	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	kind of work done of OO NOT use retired	during most of worki	ing		,
N Wit	giene er the	Completed	12	30110gC (1 401 01)		Inspect	or		Automotiv	re
3 1	al Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name			
ould t	Ment arke	2	John Longstreth				Nell C	artwrigh	t	
2 sh	is m		19a. Informant's Name/Relationship (Typ						City or Town, State, Zip	
and	lealth im 27 her ti			Wife)	1412	Harberson	n Road We		ark, Maryla	
§ §	or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	BINOVALITORI STATE		sition (Name of natory or other plac	l l		Dc. Location - City or To	
it. Pages	rtmer		 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License 		7		Pk 3-8-	2005 S	ykesville,	Maryland
Dermi Dermi	mpo any		21. Signature of Funeral Service License	I love not a	, Wi	Name and Addres Ltzke Fun	eral Home	of Cato	nsville, In	nc.
			23a. Part1. Enter the disease, or complic	cations that caused the death.					ille, Maryl	and 21228 Approximate
DI-			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	1	1 1	/		.,	Interval Between Onget and Death
	ysician Medical		disease or condition resulting in death)	Due to (or as a conseque	1745	mhc	My	Como	er	195
Ex	aminer			Due to (or as a conseque	(, ,)	1 1 2	Lactho	of S		2006206
		ē	Sequentially list conditions.	Due to (or se a conseque	nea ui):	Line	TRITITIE	2.1.5		V
petro	nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
e be exe	an ar ırial-t	EX	resulting in death) Last	Due to (or as a conseque	ence of):					
ate b	physician and the burial-transit	licai	d							
	the attending phy ched for use as th	Physician/Med	IF FEMALE:							
atho	ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal of	leath 3 🗆	Ectopic pregnancy			23d. Date of delive Month	ry Day Year
. e	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of dea 9 ☐ Unknown	ıth 5∐	Other (specify)				Jay Tour
that	ed by detac		Part II. Other significant conditions con	tributing to death but not result	ing in the un	iderlying cause give	en in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
ures a	been signed by the atte should be detached for	d by							2 □No 3 □ Prob	
§ §	s been s	ojete						24a. Was an	24b. Were auto	psy findings available
The la	page 2	Completed						autopsy	prior to cor death?	npletion of cause of
en:	certificate rector. pag	0	25. Was case referred to medical				26. Place of Death	(Check only one)	No 1 □ Yes	2[_] NO
ysic	n. After this certific funeral director.	To B	examiner?	ospital: 1 Inpatient 2 El	R/Outpatient	3 □ DOA Othe	er: 4 🗌 Nursing Hor	ne 5 esiden	ce 6 Other (Specify	')
) id	n. After this funeral di		27. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work	at 2	28d. Describe how	injury occurred	
and i	or: A the fu	catle	2 Accident investigation				res 2 □ No			
or Att	Diract Diract in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	eet, factory, office	2	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
DIVISION OF VICE INCOMES, IT.O. DOX 007 007, OF TO the Hospitel or Attending Physicien: The law requires that the death certificate be executed	within 24 hours after death. To the Funerel Diractor: A completely filled in by the fu		29a. Certifier 12 Certifying Phys	ician: To the best of my knowler: On the basis of examination	edge, death	occurred at the tim	e, date and place, a	and due to the cau	se(s) and manner as st	ated.
the	thin 2, tha F mplete	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License				
To.	₹ ¥ 8		A Section of the sect	n (may.		9-97	1.9	1. Date signed (Month), I	05
1)	171		30. Name and address of person who con	mpleted cause of death (Item 2	23a) (Type I	Print)	- ()	, , ,	7/1/	7/7,70
C	•		in prie ino D	Albronne	ay	5-16	w. Roll	ing Pol	Butto	and
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 4 2005	31 Registrar's Signary	Spa Spa	de				

			1 - For State Registrar	State of Mary		artment of I rtificate of		nd Mental Hy	ygiene Reg. No	UUU.	07230
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of D	eath Dav	y Year	3. Time of Death
	/Media		Shirley Ann					FEB	26	2005	1:00 PM
	Examin	er	4a. Facility Name (If not institution, give : 1409 Saybrooke Co			4b. City, Town, Pas	or Location of adena	Death		. County of Death Anne Aru	
	Funeral Director		3//-12-1433	7. Age (In	yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Date of B Min. (Month, D March	irth 22 Year	919 9. Birth	place (State or Foreign ntry) DC
	land ow		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation					10d. Inside City Limits
	Man pa-f sh	tor	Maryland Anne An	rundel		F	asaden	ıa			1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Cou	ntry?
	s 23a	ral	1409 Saybrooke Co				2112			USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show important: If item 27 is marked other than "natural", or items 23a or 28a-1 show all propriety injury or other traumatic event, the Madical Examinar must be notified at ODGE.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of if Yes, specify Cub 1 ☐ Yes 2 🔯 No		n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: W	
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	dent's Usual Occu	pation	of working	16b. K	ind of Business/In	dustry
2	han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	*		.,		
2	filed v Hygie ther t int, in		12 17. Father's Name (First, Middle, Last)		Admin	istrativ		STANT s Name (First, Middle		S Govern	ment
ylan	Mental	To Be	Harold J. Yauch	ler				e Naomi	Brow		
Baltimore, Maryland 21215-0036	nd 2 sho alth and 27 Is m r traum		19a. Informant's Name/Relationship (Ty Patricia Massof (C		19b. Mailir 140	ng Address <i>(Street</i> 19 Saybro	and Number Oke Col	or Rural Route Numi urt, Pasac	_{ber, City o} dena ,	or Town, State, Zip MD 2112	Code)
ore,	of Heg		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of natory or other pla	ce) NA -	Date	20c. Lc	ocation - City or To	own, State
<u><u>E</u></u>	Page nent c ant: If ury or		1 🔀 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State	Gate of H			rch 03 2005	Silv	er Sprin	g, Maryland
Balt	permit. Departi Import any inj		21. Signature of Funeral Service License	ngs saden	Funeral	Home, P.A.					
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the re cause on each line.	death. Do not ent						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	CEREB	ROVAS	win	2 D	ISEASE	5		Onset and Death
	/Medical Examiner		resulting in dealth)	Due to (or as a co	nsequence of):						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							3	
Ó	an an arial-tr	Exa	resulting in death) Last	Due to (or as a co	nsequence of):						
8760,	cate be executed obysician and the burial-transit	dlcal		i							
9	ertific Jing p	/Mec	IF FEMALE:	20 16						ŀ	
.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pi 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify) _	у		4	23d. Date of delive Month	ery Day Year
Φ.	res that igned b be deta		Part II. Other significant conditions con	tributing to death but no	ot resulting in the ur	nderlying cause gr	ven in Part I.	23e. Did	tobacco u	ise contribute to th	he cause of death?
ord	w require been sig should b	ted	Brain tu	mor				_ 10	Yes 2	□ No 3 □ Prob	pably 4 Dinknown
Vital Records,		Completed by						24a. Was auto perf 1 \(\text{Yes}		24b. Were auto prior to con death?	psy findings available mpletion of cause of
Vita	ilclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		04		f Death (Check only			
	문 등 등	. To	1 Yes 2 No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of	t 3 DOA	er: 4 ☐ Nursi	ing Home 5 Res 28d. Describe	idence 6	6 Other (Specify	1)
0	ding h. Afte fune	tlon	11 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	₩o		1	now injur	y occurred	
Division of	in Light of	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stropecify)	eet, factory, office		28f. Location City or To	(Street and wn, State)	d Number or Rura)	I Route Number,
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Physics (Check only one)	sician: To the best of maner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the tivestigation, in my	me, date and p ppinion, death	place, and due to the occurred at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	_		29c. Licens	e number		29d. Dat	e signed (Month,	Day, Year)
) menigo	MD		I	575	531	FE	B 28	2005
	X		30. Name and address of person who co	mpleted cause of death 2601 VCI 32. Registrates \$	(Item 23a) (Type,	Print)					
	, (10	31. Date filed (Month, Day, Mr)	32. Registrates	erans Signature	newy	ny	Verson	12	140	21108_
	Sta Registr		MAD 0 4	2005	me . H.	Snade					

				1- State of Maryland / Department of Health and Mer State of Maryland / Department of Health and Mer Certificate of Death	ntal Hygien	le
		Physici /Medio Examin	al		EBROSET	Day 2 Year 3 Time of Death 28 2005 9/6 PM
11		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. 430 - 44 - 3007 1 M 2 F 6 Yrs. Wonths Days Hours Min. 1 Usual Residence of Decedent	Date of Birth (Month, Day, Yea) C. , , , , ,	9. Bitthplace (State or Foreign Country)
soly		the Marylan 28a-f show	ctor	Maryland NA Baltimore		10d. Inside City Limits 1 ☑ Yes 2 □ No
Cour		ath with th	Funeral Director	10e. Street and Number 10f. Zip Code 2823 W. Lanuale St. 21216	10g. C	Citizen of What Country?
MAN.	5-0036	ours after dea rel', or Items Examiner nu	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 No let Yes, Specify Cuban, Mexican, Puerto Rica State Stat	/ Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: A C
255	21215-0	d within 72 ho giene. r then "netui the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary(Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/Industry FUCKING CO.
Har	/land	S should be filed and Mental Hyg is marked other sumatic event, l	To Be C	17. Father's Name (First, Middle, Last) Nathaniel Creasy 18. Mother's Name (Fi	irst, Middle, Maide	an Sumame)
- How	nore, Mary	of Health of Health If item 27 or other tre		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Relationship (Type, Print) 20b. Place of Disposition (Name of cemerery crematory or other place) 1 Burial 2 Cremation 3 Removal from State New Fork Bapt. Church 3-8-05	ane Po	v or Town, State, Zip Code) Location City or Town, State Lmyra, Va
8	Baltimor	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3. Seph L. Russe	uneral 1	Home 7. Md. 21216
		Physician /Medical		23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ispiratory arrest,	Approximate Interval Between Onset and Death
	8760,	eate be executed bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
	P.O. Box 68	he death certific r the attending pl ched for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
	of Vital Records, P.	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FALLURE	1 ☐ Yes	o use contribute to the cause of death? 2 No 3 Probably 4 Wifknown 24b. Were autopsy findings available prior to completion of cause of
	tal Re	en: The l tificate ha tor, page	Be Com	25. Was case referred to medical 26. Place of Death (Ci	autopsy performed? 1 Yes 2 N Check only one)	death?
	ion of Vi	nding Physici ath. r: After this cer e funeral direc	2	examiner? 1		
	Division	tal or Atters after de el Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f.	Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
		the Hospi in 24 hou the Funer pletely fill	ledical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and place, and control one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and manner stated.	at the time, date ar	nd place, and due to the cause(s)
		with To	Σ	29b. Signature and little of Certifier 29c. License number D0051586		BRURY 28, 2005
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR VICTOR KIM 2401 WEST BEVEDERE	AVE.	BALTIMORE, MOZIELS
		Sta Regista		31. Date filed (Month, Day, Year) MAR 0 4 2005		

			For State of Registrar		d / Dep		Health and N	Mental Hygi	•	07232
•	Physicia /Medica Examine	al .	n. Decedent's Name (First, Middle, Last) Marian Catherine Mc la. Facility Name (If not institution, give street and nun North Arundel Hospit	nber)			or Location of Death Burnie	2. Date of Death Month	Day Year 2 2005 4c. County of Dea Anne Ar	th
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F Usual Residence of Decedent	7. Age (In yrs. I		y) If Under 1 Year Months Days		8. Date of Birth (Month, Day, 11/06/1	9. Bir Co L 9 3 7	thplace (State or Foreign puntry) MD
:	death with the Maryland ms 23a or 28a-f show r must be nutified at	Director	10a. State 10b. County MD Baltimore 10e. Street and Number	1	Town or	River 10f. Zip Code		10	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
5-0036	urs after	by Funerai	1307 Gunpowder Cross 11. Marital Status 1 □ Never Married 2 □ Married 3 ■ Widowed 4 □ Divorced 1 □ Ves Giv Year or De	dent Ever in U.Sces? 21X No		2122 . Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - Ame Black, Whit	
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(1.₩V Maryland	A 20 6 1	To Be	17. Father's Name (First, Middle, Last) Charles M. Dell 19a. Informant's Name/Relationship (Type, Print)	ughter	19b. Ma	iling Address (Stree	Marga	e (First, Middle, Me cet I. I al Route Number, (Zip Code)
MAHU Baltimore, M	Pages 1 and 2 nent of Health int: if item 27 I iry or other tre		Katherine M. Bardrof 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 8 4 Donation 5 Other (Specify)	f7	ace of Disponetery, cr	54 St. M. position (Name of ematory or other place Park Ce	ice)	Date 20	altimore Oc. Location - City or Baltimor	
Baltir	permit. Pages Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee			22. Name and Addr 169 Rivi	era Driv	J.Gonce ve, Pasa	Funeral adena, M	Home, PA
760,	bullicie	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	used the death ach line. Or as a consequence as a conseq	ence of):	. 1.	ng, such as cardiac		it.	Approximate Interval Between Onset and Death
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ital Rec		e Completed	25. Was case referred to medical				26. Place of Deat	24a. Was an autopsy performe 1 Yes 2	prior to death? No 1 □ Yes	itopsy findings available completion of cause of
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	n 24 hours after on A Funeral Director of Fune	edical Ce	29a. Certifier (Check only one) Certifying Physician: To the based and mann	sis of examinati	vledge, dea ion and/or	ath occurred at the tinvestigation, in my	me, date and place, opinion, death occur	and due to the cau	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the complet	N.	29b. Signature and title of certifier 30 Name and addless of person who completed cause	M of death (Item	23a) (Typ	29c. Licen D 4	3977	M	d. Date signed (Mont.	h, Day, Year)
	Stat Registra		31. Date filed (Month, Day, Year) 32. R. MAR 0 4 2003	egistrar salignat		& Spark	len Bh	nc. W	UD. 011	pb/.

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			Ear	State of Maryl	and / Depa	artment of h	lealth and	Mental Hy	giene	
			1 - For State Registrar	ĺ	-	rtificate of		-	Reg. No:	07233
	Dhorisi		1. Decedent's Name (First, Middle, La	st)	-			2. Date of De	eath Day Ye	3. Time of Death
	Physici /Medic				edley			Feb.	23, 2005	4:30A M
	Examin	er	4a. Facility Name (If not institution, giv				r Location of Dea		4c. County of D	
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	Funeral Director			☐ M 2덫F	58 Yrs.	Months Days	Hours Min		1, 1946	Birthplace (State or Foreign Country) VA
	D		Usuel Residence of Decedent					DCO. 1		
	anylar show	'n	10a. State 10b. County		City, Town or Lo		a			10d. Inside City Limits 1X☐ Yes 2 ☐ No
	the M	ecto	Md. Montgo	mery		Silver	Spring		10g. Citizen of Wha	
	with 3e or	I Dir	11432 Encore I	rive			0901		United	
	death ma 2;	by Funeral Director	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.	Was Decedent of H		Specify Yes or No		American Indian,
9	after or ita	/ Fui	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📆 No If Yes, Give		ni Yes, specny Cub 1 □ Yes 25☑ No	an, mexican, Pue Specify:	rto Hican, etc.)	Specify:	Vhite, etc.
8	be filed within 72 hours after death with the Maryland tital Hygiene. od other than "natural", or Itama 23e or 28e-1 show event, Itam Medical Ever their rival for modified at	d b	3 Widowed 4 Divorced	Year or Dates:					I	Black
1 5	in 72	Completed	15. Decedent's Education (Specify only highest gradual)	ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Busine	ess/Industry
212	e filed within all Hygiene. I other than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Admir	nistrati	ve Ass	istant	Howard	Univ.
b	be filed stal Hygi of other	Bec	17. Father's Name (First, Middle, Last,)			18. Mother's Na	me (First, Middle	, Maiden Sumame)	
yla	should be nd Mental marked o	To	Leonard R. Med				Betty			
Maryland 21215-0036	12 sh h and 7 lam raum		19a. Informant's Name/Relationship (1143	32 Encor	ce Driv	e	er, City or Town, Sta	te, Zip Code)
	1 and Healtl am 2		Samuel O'Neal/		b. Place of Dispo	er Spri		. 20901	20c. Location - City	or Town, State
nor	ages ant of it: if it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, crei	matory`or other pla le Crema	-	12/05		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 la marked eny injury or other traumatic espoce.		21. Signature of Funeral Service Licer						Edwards	erdale, Md.
ñ	Depa Impo eny ii		Chanice 9	dwards						d, Md. 20746
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a Massive	Pulmon	arv Emb	olism			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con			0			
		-	Sequentially list conditions,	b. Cerebral		litis				
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	Multiple		osis				
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9	death certifica e attending ph id for use as th	Med	IF FEMALE:							
Вох	leath certific attending p I for use as I	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3	Ectopic pregnancy	/		23d. Date of Month	delivery Day Year
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	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribut	te to the cause of death?
Records,	w requires been sign should be	q pa	Diabetes Melli	tus Type I	I			1 🗆 '	Yes 2 No 3	Probably 4 Unknown
000	aw re	plet						24a. Was		e autopsy findings available to completion of cause of
Ä	The ate his page	Completed						autor perfo	ormed? deat	h?
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of	S S =	2	1 ☐ Yes 2 🛣 No 27. Manner of Death		2 ER/Outpatier		4 A Nursing		dence 6 Other (S	Specify)
no	fter Ther	tlon	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea.	r) Injury	Wor	yai k? Yes 2∐No	28d. Describe	how injury occurred	
Division	Attending r death. actor; Afte	flca	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury - A	At home, farm, str			28f. Location (Street and Number o	r Rural Route Number,
á	s after N Dire	Certification;	4 Homicide determined	building, etc. (Sp	ecity)			City or To	wn, State)	
	To the Huspital or Attendia within 24 hours after death. To the Funeral Diractor; A completely filled in by the fu	edical (29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	nysician: To the best of my miner: On the basis of exan	knowledge, death	h occurred at the tir	ne, date and plac	e, and due to the	cause(s) and manne	r as stated.
	the h	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (M	
)	Will To Col		Salma Salma	Khomo	ali		58965			
7	1)		30. Name and address of person who		/				repruary	23, 2005
	1/		Dr. Saina Khaw	aja, 11119	Rockvi		e, Suit	e #100	, Rockvi	lle,Md.
	Sta		31. Date filed (Manth Day) Year) 20		anature 4	reles				***************************************
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	amend its		5,perFH,C841,3/28/05 TT Please Ty	pe or Print in E	Black Inc	delible Ink.	Ensure A	II Copies	s Are Legible.	
			AMEND ITEM #1 PI	State of Marylan	3/1668	70270466	ealth and I	Mental Hy	giene) 005	07221
			Hadistral AMENT LINM 1	1 PER PHY g	341 99	tificate 19th	Death		neg. No.	0/234
	Physici		1. Decedent's Name (First, Middle, Last)	AV FLIZARITI	TI MIZZI	YELISABE	TH MEZEY	2. Date of De Month Februa	Day Year	3. Time of Death 8:20 P M
	/Medio		4a. Facility Name (If not institution, give str	-			Location of Death		4c. County of Dea	ath
			Blakehurst 5. Secial Security Number 6. Sex	7. Age (In yrs.	In a & friedfaller ()	Towson If Under 1 Year	If Under 24 Hrs.	S Data of Bi	Baltimore	
	Funeral Director			y 2√F 96	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D. March 5	, 1908 Swi	nthplace (State or Foreign ountry) tzerland
	yland yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	8a-fs	ector	MD Baltimore	Tow	son					1 □Yes 2 □No
	death with the Maryland ma 23a or 28a-f show rmust be notified at	Funeral Director	10e. Street and Number 1055 W. Joppa Road	Apt. 412		10f. Zip Code = 21204			10g. Citizen of What C	ountry?
	ema 2	inera		. Was Decedent Ever in U. Armed Forces?	.S. 13. \	Was Decedent of Hi	spanic Origin? (Sp n. Mexican, Puerto	pecify Yes or No		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Madical Examinar must be mailtied at any injury or other traumatic event, the Madical Examinar must be mailtied at ance.	by	1 ☐ Never Married 2 🛣 Married . 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 1 No If Yes, Give Year or Dates:		I□Yes 2□XNo	Specify:	,	Specify: Wh	
5-0	natur	eted	15. Decedent's Educa (Specify only highest grade of	ition completed)	(Give	lent's Usual Occupa kind of work done of OO NOT use retired.	furing most of worl	king	16b. Kind of Business	/Industry
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	and 2 ealth a m 27 is		Dr. Kalman C. Meze			CT INC. NAME OF THE OWNER,	and the same of th		Towson, MD	
Baltimore,	ages 1 nt of H I: If ite		20a. Method of Disposition 1 ☐ Burial 3 XCremation 3 ☐ Rei	moval from State	emetery, cren	sition (Name of natory or other place ervice Co	9)	Date / N.F.	Towson, MD	
altin	permit. Page Department Important: Il any injury o		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Finefal Service Lifenses	,,,,,	<u> </u>	. Name and Addres	-	703	1050 Yor	
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			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	of that caused the death of the death of the cause on each line.	h. Do not ent	er the mode of dying Terminal	g, such as cardiac Aspira	or respiratory a tion	rrest,	Approximate Interval Between Onset and Death
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of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical			24	26. Place of Deal			
	Phys this al di	To L	1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of		4 - Nursing no		dence 6 Other (Spe	ecify)
sion	Attending I ar death. ector: After by the funer	ation	1 Natural 5 Pending investigation	(Month, Day Year)	Injury		? /es 2 □ No			
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	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medicai C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medicel Examine	cien: To the best of my kno ir: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the time restigation, in my op	e, date and place, sinion, death occur	and due to the red at the time,	cause(s) and manner as date and place, and due	s stated. a to the cause(s)
	To the within To the complé	Me	29b. Signature and title of certifier	and marinor states.		29c. License	number		29d. Date signed (Mont	
•	1.6		I will is h	~ Com		1)4	7178		2-24	-05
_	24		30. Name and address of person who com	lilonnel	1 6	Print) ,301 N	. Cha	les	Balton	are 2/2/2
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 4 2005	32. Registrar's Signa		W				

M.D. Nay, Patricia by Cleared

Baltimore.

68760.

Box (

P.O.

Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 5 per Th 8841 3-23-05 vt.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** February 28, 5:20 PM Nancy West Mrozinski 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 5214 Oakland Road Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5007-227-6600 **Funeral** 1 ☐ M 2 🛣 F Months Days Hours Min. Yrs. Director 84 -07 January 23, 1921 Maine Usual Residence of Decedent with the Maryland 10c City Town or Location 10a State 10d, Inside City Limits 10h County 28a-f show ral, or items 23a or 28a-f shov Exstrict must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 5214 Oakland Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced "natural" White if Health and Mental Hygiene. itam 27 Ia marked other than "natur other traumatic evant, Ite M. Jic. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 5+ Homemaker Own Home 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden, Sumame) Be 2 should be fi and Mental H ပ္ Vernon F. West Charlotte Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an 1100 South Lake Drive #13 Lantana, Florida 33462 Andrew Richard Mrozinski/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Montgomery Crematorium Inc. March 3, 2005 *4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00335Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, ox complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician Alzheimer's Disease 4 Years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hypertensive Cardiovascular Disease With Bradycardia Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner sician and burial-transit be executed Anema and Dehydration that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No for Month Day Year 4 Pregnant at time of death 5 Other (specify) à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Osteoporosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan Kyphoscoliosis autopsy 1 Yes 2**X** № Division of Vital To the Hospital or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ို 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To tha Funaral DI completely filled in 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 4162 (D.C.) rala O. lonna, MD March 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

Registrar

Tecla O. Lovina, M.D.

MAR 0 4 2005

31. Date filed (Month, Day, Year)

32. Restrar's Signature

4124 Warren Street N.W. Washington, D.C. 20016

			1 - State Registrar	ate of Ma	ryland /		artment tificate			ınd M		giene Reg. No.	711115	07236
	°. Physicia	an	Decedent's Name (First, Middle, Last)		-						2. Date of De Month		, 2005	3. Time of Death
	/Medic	al	Frank Merendino, Sr 4a. Facility Name (If not institution, give stree				4b Ciby	Town or	Location o	f Doath	Februa		County of Deat	7:15 P. M
	Examin		Mary's House	t and number)			Rock			i Dealli			ntgomer	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last	birthday)	If Under	1 Year	If Under 2	24 Hrs. Min.	8. Date of Bir			holace (State or Foreign
h	Director		081-18-4637	2 F	79	Yrs.	WOTTERS	Days	Hours	IVIII I.	8. Date of Bir (Month, Da Oct. 18	192	25 New	York
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside City Limits
	Mary If ah	tor	Maryland Montgomery		Rockv	ille								1∭Yes 2 No
	th the	Directo	10e. Street and Number				10f. Zip	Code				10g. Citi:	zen of What Co	untry?
	ath wi	ral	600 A Veirs Mill Roa	d, Room	#11			852					ed Stat	es
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28a-f ahow Item Medical Evary art must be traffied at	by Funeral	1 Never Married 2 Married 1	Vas Decedent Ev Armed Forces?			Vas Deced f Yes, spec		spanic Orig n, Mexican Specify:	jin? (Spe , Puerto	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify: Whi	e, etc.
2-0	72 hou	ted	15. Decedent's Educatio		16	Sa. Deced	lent's Usua kind of wor	I Occupa	ition	of works	na		nd of Business/	
21	0	Completed	(Specify only highest grade cor	College (1-4or 5+	·) D	rint	OO NOT us	e retired)	urng mosi)	OF WORK	ng	Fodo	mal Cor	vernment
121	Hyg Tha		17. Father's Name (First, Middle, Last)		1	1 1110	<u> </u>		18 Mothe	r's Name	(First, Middle			eliment
Maryland 21215-0036	D 22 D 0	To Be	Jerome Merendino								Signore		ourrame,	
ary	s 1 and 2 should f Health and Meritam 27 is marks othar traumatic	F	19a. Informant's Name/Relationship (Type, F	Print)	1:	9b. Mailin	g Address						Town, State, Z	Tip Code)
Σ,	and 2 ealth a m 27 is		Frank Merendino, Jr.					•	r Cou				rg, MD.	
Baltimore,	ges 1 an t of Heal if itam 2 or other		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Remo	val from State	20b. Place ceme Gate	tery, cren	natory or of	ther place	⁹⁾ M	arch	ate 14,		cation - City or	
Itim	it. Par rtmen rtant: njury	4	'4 □Donation 5 □ Other (Specify)			mete	rv			200.	5			, Maryland
Bal	permit. Pages. Department of the Important: If its any injury or of once.		21. Signature of Funeral Service License		м01353	Ro	ckvil	le,	Mary.	Land	20850-	2805	omery A	neral Home/ venue
The state of the s	Pnysician /Medical Examiner		23a. Pant1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Cholan Due to (or as a	io Car	cino ce of):		e of aying	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death Months
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ls, P	as the	by	Part II. Other significant conditions contribu	iting to death but	not resulting	g in the un	nderlying ca	ause give	n in Part I.			_		the cause of death?
Sorc	w require been sig should b	eted		· · · ·						_			_	· · · · · · · · · · · · · · · · · · ·
Il Records,	The lar ate has page 2	Completed											prior to death?	topsy findings available ompletion of cause of 2 No
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	tal:				Othe			(Check only o		_ A	ssisted W Livin
of		n: To	1 ☐ Yes 2 🛣 No 27. Manner of Death 28	1 ☐ Inpatient 3a. Date of Injury	285	. Time of		Bc. Injury Work			ne 5 Resi 28d. Describe I			ii) Livin
ion	fe Age	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear)	Injury	М		? ′es 2 □ N	10				
Division	l or Atten after deat Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 26	Be. Place of Injury building, etc.		farm, stre	eet, factory,	, office		:	28f. Location (S City or Tox			ral Route Number,
_	Hospital 4 hours Funaral ely filled	edical C	29a. Certifier (Check only one) 1 💢 Certifying Physicia 2 Medical Examiner:	n: To the best of On the basis of e and manner state	examination	lge, death	occurred a restigation,	at the time in my op	e, date and inion, deat	i place, a	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To tha within 2. To the complet	Ž	29b. Signature and the of certifier	1 <	1	7		. License					signed (Month	
					7/	>		36046	5			Febru	uary 28	, 2005
_	30+1		30. Name and address of person who complete John J. Merendino, M.D.	10215 Fe	rnwood	Drive		uite	# 40	5, B	ethesda	ı, Ma	ryland	20817
:1:	Sta Registr		31. Dae filled (Month, Day, Year) MAR 0 4 2005	32. Resistrar	's Signature									

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and N 1- State Registrer Certificate of Death	Mental	Hygie Reg.		05	078	237
ľ	a,		1. Decedent's Name (First, Middle, Last)	2. Date Mont	of Death	Day	Year	3. Time of	Death
	Physicia /Medic		Marian G.M. McLaughlin			26 , 2		2:40	РМ
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1		4c. County	of Death		
			Hebrew Home of Greater Washington Rockville			Mont	gomer		
	Funeral		5. Social Security Number 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Yrs Months Days Hours Min.	8. Date (Mont	th, Day, Ye	ar)	9. Birthp	lace (State o	r Foreign
	Director		102-05-7182	Oct.	19,	1911	Ne	w York	
	and #	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				1	0d. Inside Ci	ty Limits
	Mary f sho	ō	Maryland Montgomery Olney				Ì	1 🗌 Yes	2 ⊋ No
	28a	Directo	10e. Street and Number 10ff. Zip Code		10g.	Citizen of	What Cour	ntry?	
	death with the Maryland ims 23a or 28a-f show ir must be rodified at	0	18800 Luray Court 20832		III	nited	Stat	A C	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14 yes, specify Cuban, Mexican, Puerton U.S.)	pecify Yes	or No-	14. Rad	ce - Americ	an Indian,	
0	or Ite		1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:	o nican, en	v.)		ck, White,	etc.	
2-0020	ural',	d by	3 ☑ Widowed 4 □ Divorced Year or Dates:			Specif	Whi	te	
2	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	king	16b	. Kind of B	usiness/In	dustry	
V	within ane.	mp	Elementary/Secondary (0-12) College (1-4or 5+) 2 Bookkeeper			Dod	tail		
7	Hygie Hygie ther t	မ ငိ	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, M	liddle. Mai				
alla	d be ental red o	To Be	Francis Gunn France				,		
<u></u>	shoul of Me mari	F	19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Ru				State, Zip	Code)	
Z S	nd 2 alth a 27 is r trau		Virginia Anderson/ Daughter 18800 Luray Court, 01	ney,	Mary]	land 2	20832		
ā,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ance.	,	20a. Method of Disposition 20b. Place of Disposition (Name of completery, crematory or other place) Marc	Date h 29,	200	. Location	- City or To	wn, State	
Ē	Page nent c int: If		'4 Donation 5 Other (Specify) National Cemetery 20	05	Aı	-linot	on.	Virgin	ia
Sallimor	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee M01405 22. Name and Address of Facility Ro Rockville, Inc. 30 Rockville, Marylan	bert	A. Pi	ımphre	y Fu	neral	Home/
מ	99 = 9		M01405 Rockville, Marylan	d 208	50 Mor	rtgome	ery A	venue	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each fine.	or respirat	ory arrest,			Approximate interval Bets	ween
	Physician		Immediate Cause (Final disease or condition a Respiratory Failure					Onset and I	Jeath
	/Medical Examiner		resulting in death) Due to (or as a consequence of):						
	LABITITIE	h.	Sequentially list conditions, b. Aspiration Pneumonia						
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6	be executed ician and burial-transit	хап	that initiated events c. resulting in death) Last Due to (or as a consequence of):			-			
2/00	eath certificate be executed attending physician and for use as the burial-transit	<u>a</u>							
00	certificate Iding phys	edic	<u> </u>						
X Q Q	n cert	<u>N</u>	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d. Da	ite of delive	ery	
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cora	equir sen s ould	ted			1 Tes	2 ∐ No	3 🗆 Prob	ably 4 🛣	Jnknown
ပ်	> 0 70	ompieted		24a.	Was an autopsy		prior to cor	psy findings a mpletion of ca	available ause of
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VItal	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner? Localizat 26. Place of Dea						
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	ding Phy h. After thi funeral	ion:	1 XNatural 5 ☐ Pending (Month, Day Year) fnjury Work?	200. 0030	NIDO NOM I	ingury occur	100		
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2	spital or Al burs after of leral Direc filled in by	erti	3 Suicide determined determined determined determined building, etc. (Specify)	City o	or Town, S	tate)			
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place						
	To the Hos within 24 h To the Fur completely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	rred at the	time, date	and place,	and due to	the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier 29c. License number			Date signe			
			> Shilpa H. Cemus. MD D0002713		re	pna	15 2	8,200)
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHILPA H- AMINIMD, 6121 Montrose Road, Rockv	ille,	Mary	land	2085	2	
• 4	Sta Registr		31. Date filed (Moeth Day, Year) 4 2005 32. Poistrar's Signature						
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			For State Registrar		State o	of Maryl	land / [Depa <i>Cei</i>	artmen rtificat	t of H e of L	lealth a	and M		leg. No.		75	072	
	Physici	an	1. Decedent's Name (First, Mi Carl Henry		1 م								2. Date of Dea Month Februar	Day	7, 2	Year 2005	3. Time of	Death P M
	/Medic Examin		4a. Facility Name (If not institu			ımber)			4b. City,	Town, or	Location of	of Death	Tebruar			of Death	3.40	, r
	Examin	er	Gilchrist	, 3						owsc					-	timo	re	
F	Funeral		5. Social Security Number	6. Sex			yrs. last bii		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	Year)		9. Birthp	lace (State o	or Foreign
	Director		214-16-6512	143	M 2□F	84		Yrs.			, , , , , ,		8/23/19				yland	
	land	1	Usual Residence of Decedent 10a. State 10b. Cou	nty		100	c. City, Tow	n or Lo	cation					_		1	0d. Inside C	ity Limits
	Mary -f sh	tor	MD Balı	imor	e		Ba1t	imo	re								1 ☐ Yes	2 🔯 No
	or 28c	Director	10e. Street and Number						10f. Zip	Code				10g. Citi	zen of W	Vhat Coun	try?	
	ath wi	rai	133 Sipple A					,		2123					U.S.			
	items	Funerai	11. Marital Status		12. Was Dec	orces?	in U.S.	13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Ori ın, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)			e - Americ k, White,		
36	irs aft	by F	1 ☐ Never Married 2 ☐ M 3XXVidowed 4 ☐ Divora		If Yes, Gi Year or D	2 No ive Dates:			1 🗆 Yes	2 √2 No	Specify:				Specify.	Whi	te	
9	2 hou	ted		dent's Educ			16a	Dece	dent's Usua	al Occupa	ation during mos	t of worki				siness/Ind		
21	ithin 7	Completed	(Specify only hig Elementary/Secondary (0-1)			1-4or 5+)		life.	DO NOT us	se retirea	d) mos	t of works	rig					
121	filad within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Hems 23a or 28e-f show that the Medical Examinar must be notified at		10 17. Father's Name (First, Midd	tlo (ast)				Ins	pecto	r	19 Moths	or's Name	(First, Middle,				ectric	
Maryland 21215-0036	gas 1 and 2 should be filad within 72 hours atter death with the Marylan It of Health and Mental Hygene. If item 27 is marked other then "naturel", or Items 23a or 28e-1 show or other traumatic evant. The Medical Examinar must be notified at	To Be	John Mannel	iie, Lasi)									et Evere		Sumam	θ)		
ary	shou and M s mar	-	19a. Informant's Name/Relation						_				I Route Numbe	-				
	1 and 2 Health em 27 I		Kathleen Moor	ney/N	iece	100			_				Baltimo			-		4
Baltimore,	parmit. Pagas 1 and 3 Department of Health Important: If item 27 eny injury or other tr once.		20a, Method of Disposition 1 Burial 2 Crematic	on 3 □R	emoval from	State	0b. Place o cemete				1		Date	20c. Lo	cation - (City or To	wn, State	
Ë	Pa		'4 □ Donation 5 □ Other				Gard		of F			3/4/					Maryla	
Bal	parmit. Departn Imports eny inju	0419 Belair Road Bartimore, Maryland 21200																
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	and I-trans	Examiner	that initiated events resulting in death) Last	٥		(or as a cor	nsequence	of):										
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687	g phys as the	ledic																
XOX	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	2	3c. If yes, ou 1∐Live	itcome of problems		3 🗆	Ectopic pr	egnancy				2	23d. Date	e of delive	,	rear
O. B	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	1 Yes 2 No		4∐Preg 9∐Unkr	nant at time nown	of death	5□	Other (sp	ecify)					10101	1413	Day	i ear
σ.	res that the de signed by the a I be detached f		Part II. Other significant cond	litions cor	tributing to c	death but no	it resulting i	n the u	nderlying c	ause give	en in Part I.		23e. Did to	bacco u	se contr	ibute to th	e cause of d	leath?
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Vital	ician: The certificate rector, pag	Be	25. Was case referred to med examiner?	-	I 'A - I'.					- 011			(Check only or		VICTOR I		,	
of	Physician: this certific ral director,	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death		lospital: 1 🗆 28a. Date		2 ER/O	utpatier Time o			4 190		me 5 Resid				Mospic	e
O	ding F h. After funer	tion	1 Natural 5 ☐ Per	nding estigation	(Mor	nth, Day Yea	ar) 200.	Injury	M	8c. Injury Work	k? Yes 2⊟:		zod. Describe n	ow injury	Occurre	90		
Division	I or Attending after death. Diractor: After I in by the funer	ifica	3 ☐ Suicide 6 ☐ Co	uld not be	28e. Plac	e of Injury	At home, fa	arm, str	eet, factory	, office			28f. Location (S			er or Rura	Route Num	ber,
D	rs after of Dire	Certification:	4 nonlicide		Dulio	ling, etc. (Sp	peciry)						City or Tow	n, State)				
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely illed in by the funeral director.	Medicai	29a. Certifier Check only one)	lying Phys cal Examir	ner: On the b	e best of my pasis of exam ner stated.	y knowledge mination ar	e, death	n occurred vestigation	at the tim , in my of	ne, date an pinion, dea	d place, a th occurr	and due to the d ed at the time, o	ause(s) late and	and mar place, a	nner as st ind due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of cer	tifier					290	. License	a number		2	29d. Date	a signed	(Month, I	Day, Year)	
	4		A	90	Un	(V			*	N E	25 SC	13	(C 50	var	142	8 20	253
	5		30. Name and address of pers	son who co	mpleted cau	se of death	(Item 23a)	(Туре,	Print)	ST	- GAR	oms	u ag	21	204			
	Sta	te	31. Date filed (Month, Day, Ye		32.1	Pegistrar's S	Signature	J 4	•						- 1			
	Registr		MAR (4 20	05	Registrar's S	, St	A	mark	,								

Mannel. Carl 2/27/05 5:40 PM.

			1 - For State Registrar	State of Marylar		artment rtificate				R	eg. No.	05	07	239
п	Physici	an	Decedent's Name (First, Middle, Last)							Date of Dea Month Druar		20 Year	3. Time o	
	/Media		Frank J. Nelka							epruary				ΡМм
	Examir	er	4a. Facility Name (If not institution, give s Manor Care Towson	treet and number)		4b. City, Towson		ocation of	Death			ty of Death		
	Funeral		Social Security Number 6. Sex		last birthday)	If Under 1	Year	If Under 2		Date of Birth	1		place (State	or Foreign
и	Director		217-05-5905	M 2□F 89	Yrs.	Months	Days	Hours	Min.	uly 21	, Year) 1915	Mar	yland	
	and *		Usual Residence of Decedent 10a, State 10b, County	10c Ci	ty, Town or Lo	ocation							10d. Inside C	City Limits
	f eho	ō	Maryland N/A		timore									2 No
	28e-	Funeral Director	10e. Street and Number			10f. Zip C	ode			1	0g. Citizen o	f What Cou	ntry?	
	h with	E D	1112 S. Decker Ave	enue		2122	4			Ţ	United	State	es	
	deat	ner	11. Marital Status	2. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decede	nt of His	panic Orig	in? (Specif	y Yes or No- an, etc.)		ace - Ameri ack, White,		
36	or It	Ϋ́	1 Never Married 2 Married	1 ☐ Yes 2 🏋No If Yes, Give		1 ☐ Yes 2		Specify:		,,	Spec		ite	
21215-0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-f ehow dical Exandrat must be notified at	ed by	3 XWidowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:		dent's Usual	•	ion			16b. Kind of			
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	should be filed within nd Mental Hygiene. marked other then imetic event, Ire M.	Be (17. Father's Name (First, Middle, Last)				1			irst, Middle,	Maiden Suma	im <i>e)</i>		
yla	12 should be fi and Mental F is marked ot reumetic ever	To Be	John Nelka						la Po					
Maryland	O G 60 5	1 6	19a. Informant's Name/Relationship (Ty) Arlene Jemellaro /							oute Number Maryl:			Code)	
-	ss 1 and 2 of Health litem 27 i		20a. Method of Disposition	20b.	Place of Dispo	sition (Name	of		Date		20c. Location		own, State	
Baltimore,	permit. Pages 1 Department of He Importent: If iten eny injury or oth		1 ☑ Burial 2 ☐ Cremation 3 ☐ R. 1 ☑ Donation 5 ☐ Other (Specify)		cemetery, crer cred He				3104	105 B	altimo	re, M	arylan	ıd
alti	mit. Postim.		21. Signature of Funeral Service License							da Fun				
ä	Depar Depar Impo		Espariel L.	Mahar	28	329 Hu	dson	Stre	et B	altimo	re, Ma	rylan	3 2122	4
			23a. Part1. Enter the disea r complication shock, or heart failure ist only on	cations that caused the dea e cause on each line.	th. Do not ent	er the mode	of dying,	such as c	ardiac or re	espiratory arr	est,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition	Due to (or as a consec					ea				Onset and	Death MIS
1	/Medical Examiner		resulting in death)	Due to (or as a consec	quenc⊌ ot):	7							J	
	Examino,	<u>.</u>	Sequentially list conditions,	. Due to (or as a consec	nuence of):									-
,	nted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(,									
<u>_</u>	executing and and and and and and and and and and	Exa	that initiated events cresulting in death) Last	Due to (or as a consec	quence of);									
8760,	ysicia	icai	L.											
39)	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: WA											
Вох	ath ce	lan/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	aldeath 3□	Ectopic pre						ate of deliver	,	Year
P.O. I	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of of 9☐ Unknown	leath 5∟	Other (spec	orty)						,	
٦.	that the ded by detail	Ph.	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cau	ise given	in Part I.		23e. Did to	oacco use co	ntribute to t	he cause of	death?
rds	quires n sign	q p	anemia er	id-Stage	den	ent	ia			1 □ Ye	as 2 🗆 No	3 ☐ Prot	ably 4 🖪	Unknown
000	aw requir s been si 2 should	siete	,	۵						24a. Was a	n 24b	. Were auto	psy findings mpletion of c	available
Re	The la	E O								autops perforr	med? 2 ☑ No	death?	mpletion of d 2⊠No	ause of
Division of Vital Records,	rsicien: The law s certificate has t lirector, page 2 s	Bec	25. Was case referred to medical examiner?					26. Place	of Death (C	Check only on				
> <	Physicien: r this certificatal director,	P	1 ☐ Yes 2 ☑ No H		ER/Outpatien		1	4 W Nurs	_	5 ☐ Reside			(y)	
u C	ling P	i.i.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м 280	Work?	at es 2.∐N		f. Describe ho	w injury occu	ırred		
isic	death ctor: ,	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome farm str	1		35 Z 🗆 IV	-	Location (St	reet and Num	ber or Rur	al Route Num	her
ρi	after Direct	ertif	4 Homicide determined	building, etc. (Speci	(y)	oot, lactory,	311100			City or Town				,507,
	To the Hospitel or Attending Physicien: The Within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical Certification:	29a. Certifier 1. Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my known to the basis of examination and manner stated.	owledge, death ation and/or in	occurred at vestigation, in	the time	, date and nion, death	place, and occurred	I due to the ca at the time, d	ause(s) and n ate and place	nanner as s , and due to	tated.	s)
	To the within Fo the	Me	29b. Signature and title of certifier			29c.	License	number		2	9d. Date sign	ed (Month,	Day, Year)	
				1 ~ ~	Q,		D	41	105	1	2	28	05	
	m		30. Name and address of person who co	mpleted cause of death (Iter	п 23а) (Туре	Print)		1			115	` "	170	1.1
			Ted House	MD 78	25	York	· R	9	100	US0)	1 MU	1	(20	7.
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registar's Sign	ature 🏄	Angel								
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Registrar

MARCH

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			A 101	artment of Health and Mental Hy rtificate of Death	/giene 005 07241
ı	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Izetta M. Pierce	2. Date of D Februal	eath 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Renaissance Gardens	4b. City, Town, or Location of Death Catonsville	4c. County of Death Baltimore
İ	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. Dec 8	irth 9. Birthplace (State or Foreign Country), 1917 Maryland
	inyland thow		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	the Ma 28e-f s	ecto	Maryland Baltimore Catonsvi	Lle 10f. Zip Code	1 ☐ Yes 2 ☐ No 10g. Citizen of What Country?
	th with	al Dir	713 Maiden Choice Lane	21228	United States
980	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "neturel", or Ilems 23a or 28e-f show event, the Midral Examble Living to multified at	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:	o- 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 ho ene. than "netur he Modical	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0·12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
d 2	e filed within al Hygiene. other than '	0	12 0 aud:	18. Mother's Name (First, Middle	gas company e, Maiden Surname)
ylan	2 should be and Mental Is marked o eumatic eve	To B	Edwin M. Pierce	Margaret Abey	
Mar	d 2 sho th and t7 Is m treum			ng Address (Street and Number or Rural Route Numb Hunt Ridge Road, Baltimo	
	es 1 an of Heal fitem?		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Date matory or other place)	20c. Location - City or Town, State
Baltimore,	tment tment tent: If		'4 Donation 5 Other (Specify) Meadowrid	ge Cemetery March 2,	Elkridge, Maryland
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury or other treumatic evance.			^{2. Name and Address of Facility} Hubbard Fu 19107 Wilkens Avenue, Balt	
	Pnysician /Medical Examiner	_	23a. Part1. Enter the disease of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	er the mode of dying, such as cardiac or respiratory a	Approximate Interval Batween Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease of the year) that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):		
P.O. Box (the death certificiny the attending places as t	Physiclan/Med		⊒Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month — Day Year
	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the L		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Onknown
al Records,	The lay ate has page 2	Completed		24a. Was auto perfu	
f Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check only not 3 DOA Other: Mursing Home 5 Res	
Division of	ding Ph I. After th funeral	atlon; T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury investigation		how injury occurred
Divi	itel or Att irs after d rel Direct led in by t	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	eet, factory, office 28f. Location (City or To	(Street and Number or Rural Route Number, wn, State)
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
1	To Con	~	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) D30989 Violen Choice Ln Co	tobriary c1 2005
		10	Myla M Carpenter, MD 711 Mo 31. Day filed (Month, Day, Year) 32. Registrar's Signature	iden Choice Ln Co	at solivered to
	Sta Registr		or. Bate mos (morning bay) your	nede	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6007 BALTIMORE SAMPRITAN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, MAY 5, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 F 21940745 Yrs. Director Usual Residence of Decedent 10c. City, Jown or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show or other traumatic event. The Madical Examiner must be notified at 1 Nes 2 No Completed by Funeral Director DAUTIMORK 10e. Street and Numbe 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with U.S.A. or items 23a 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cupan, Mexican, Puerto Rican, etc.) rmed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 No f Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced "naturel", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Give kind of work done during most of working life. DO NOT use retired)

SECRETARY (Specify only highest grade completed) al Hygiene. College (1-4or 5+) CLERICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be it of Health and Mental ٥ 19b. Mailing Address (Street and Number or Rural Route Number, AND 523 DE 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or Mt. 210N CEMETERY 4 □ Donation 5 □ Other (Specify) VAUGHN C. GKEENE FUNERAL HM 21. Signature of Funeral Service BALTIMORE, MAKYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Tury leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attanding Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes No
9 Unknown detached for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No |X Inpatient Certification: To 2 ER/Outpatient 3 DOA In is 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 5 Pending investigation 1. Natural 1 TYes 2 🗆 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the 29b. sanature and title of certifie 29c. License number 00053722 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMARITAN HOSP, BALTIMURE, MD JEFFREY PILLING MD

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

32. Registar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM #5 PER FH C841 3/08/05 JH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Phvllis February 24 2005 7:31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Days Hours 1 □ M 21 F 66 Yrs. Director 80 Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f show treumatic event, the Madical Examiner must be notified at Maryland Pasadena 1 Yes 2 No **Funeral Director** Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 8452 Bussenius Road 21122 or Items 23e filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Bfack, White, etc. 1 ☐ Never Married 2X Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than 'ury or other treumatic event, It a Ma. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Data Systems 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be Philip. Chenoweth Eleanore Rahe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) С. Reck Jr. (spouse) 8452 Bussenius Road, Pasadena, MD 21122 Edward March 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department o Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2005 MD Veterans Cemetery Crownsville. Marvland 21. Signature | For eral S vic Licepte 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one is see to each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrest /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Hypertension Due to (or as a consequence of): Box 68760, attending physician Completed by Physician/Medical fF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 2 X No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 XER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 3 DOA this filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After (Month, Day Year) 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29c. License number 29d. Date signed (Month, Day, Year) 0 29b. Signature and title of certifier D31344 February 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4304 Mountain Road, Pasadena, MD 21122 Pradeep Garg, M.D., 32. Restrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 4 2005 Calera Registrar

-14 S	,55		For State Registrar	State of Mary		partment of Certificate of		-	jiene eg. No. 200	5 07266
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Ye	3. Time of Death
	/Medic	al	Darry 1 4a. Facility Name (If not institution, give s	Vincent	Ro	Ab City Town	or Location of Dea	Februar	y 24, 200 4c. County of E	
	Examin	er	11310 Bottomley Re			Thurn			Freder	
	Funeral		5. Social Security Number 6. Sex		yrs. last birthd	(ay) If Under 1 Year Months Day	r If Under 24 Hr	8. Date of Birth (Month, Day	Year) 9.	Birtholace (State or Foreign Country)
	Director		539-82-7045 1 Usual Residence of Decedent	231	40 Yrs	i. -		Oct 28,	1964 1	Vashington
	Maryland f show	ior	10a. State 10b. County Maryland Frederi		c. City, Town o	Frederic	k			10d. Inside City Limits 1 X Yes 2 □ No
	in 72 hours after death with the Maryland "natural", or litems 23a or 28a-f show ledical Examinat most be notilised at	Director	10e. Street and Number 1590 Dockside Dri	ve		10f. Zip Code	21701		I0g. Citizen of Wha	
	death ms 23	Funeral	11. Marital Status	2. Was Decedent Ever	in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Specify Yes or No-	14. Race -	American Indian,
36	irs after	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1√ Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 21 N		rto Hican, etc.)	Specify:	White, etc. White
2-00	72 hou natura		15. Decedent's Edui (Specify only highest grade		16a. De	ecedent's Usual Occ	upation e during most of we	orkina	16b. Kind of Busin	ess/Industry
Maryland 21215-0036	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ive kind of work dor ie. DO NOT use reti Nputer And			Lockheed	-Martin
nd 2	othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Sumame)	
ylai		To		unior	Ross		Sandı			Creery
Mai	d 2 s h ar 7 ls trau		19a. Informant's Name/Relationship (Ty. Mrs Monika Stadel			ailing Address (Stre				
	of Health item 27 other tr		20a. Method of Disposition	20		isposition (Name of crematory or other p		Date	20c. Location - Cit	
Baltimore,	Pages ment of I ant: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	Silloval Holli State		ourg Crema	tory Mar			g, Maryland
Ball	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lieuns		100706	Keeney of 106 East.	ress of Facility Basford Church S	P.A. Fur	neral Hom	e vland 21701
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	Examiner		Sequentially list conditions		risequence or).					
	sit .	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of,					
	sate be executed thy sician and the burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
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9	artifica ing ph e as th	0	IF FEMALE:							
Box.	death certificate be executed the attending physician and ad for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 Ectopic pregnar 5 Other (specify)	cy		23d. Date of Month	f delivery Day Year
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of \	Phys this al dii	2	1 X Yes 2 No F	lospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpa	ILIBETE 3 DOA		Home 5 ☐ Resid	ence 6 🔀 Other (Specify) at scene
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	To the Hospital within 24 hours and to the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examinates	sician: To the best of my ner: On the basis of exa and manner stated.	mination and/o	or investigation, in m	opinion, death occ	curred at the time, o	late and place, and	due to the cause(s)
	To the h within 24 To the F complete	Me	29b. Signature and title of certified	11/		29c. Lice	nse number	2	29d. Date signed (A	
)	^		YVV	n			OCME		rebruary	25, 2005
	20		S. K. HOG	mpleted cause of death	(Horn 23a) (Ty		Penn Stre	et Balt:	imore, Ma	ryland 21201
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0	4 2005 Registrate	Signature	& speed				

			State of Manuand / Departmen	it of Health and Me		3	-101
			1 - State Registrar AMEND ITEM #1817 PER PHYSTh C841	e of Death	Reg	1. K. UU5 U	1245
н	Physici	an	EVELYN HUMPREY PETERSON	I RASMUSSEN	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		Evelyn Raomusson 4a. Facility Name (If not institution, give street and number) 4b. City,	Town, or Location of Death	February	y 27, 2005 8	8:35 PM M
	LXdIIIII	C.	Shady Grove Adventist Hospital	Rockville		Montgo	mery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Birthplace Country)	e (State or Foreign
	Director		529-26-0551 95 Yrs. Usual Residence of Decedent		ecember 2	4, 1909 Ut	tah
	anylan show	ڀ	10a. State 10b. County 10c. City, Town or Location			10d.	Inside City Limits
	28a-f	Director	Maryland Montgomery 10e. Street and Number 10f. Zip	Potomac	10/	g. Citizen of What Country	1 ☐ Yes 2 X No
	3e or		14800 Pettit Way	20854	,	United S	
	ems 2	Funeral		dent of Hispanic Origin? (Spec city Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - American Black, White, etc.	Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "naturel", or Items 23e or 28e-f show event. The Modical Examination Institled at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes : Year or Dates:			Specify:	
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Division	of or Attending after death. Director: After In by the fune	ifical	3 Suicide 6 Colombiad 28e. Place of Injury - At home, farm, street, factory		3f. Location (Stre	et and Number or Rural Ro	oute Number,
Ö	rs afte	Certific	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral.	dicai	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, and manner stated.	at the time, date and place, an , in my opinion, death occurred	nd due to the cau d at the time, date	se(s) and manner as stated and place, and due to the	d. ecause(s)
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	/	à	I fature lousko nay, mo	V5/9/B		Nlarch 1,	2005
	15		30 Name and address of person who completed cause of death (Item 23a) (Type, rint) / CATY I Md TOWS 0 / VI//4	D519/6 2 Fike G-/L	O, Roc	tville, M	1D 20852
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene me G84724-21-03 Las 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year FEBRUARY 28, 2005 Physician SAUNDERS 2:48 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITAL OF BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country)
 A 1□M 2**X**F 214.22.319 Months Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It has the state of See-1 show item 2.3 or 28e-1 show other treumstic event, I'm Medical Examinations to colling at MD Baltimore 1⊠Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Place 1611 EUtaw 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 14. Race · American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 X No Specify: 3 ØWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-Aor 5+) 'utter sewina 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Parrott Sterlina ashi 19a. Informant's Na elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 1 and 2 s i Health a onaway Sister 3933 Flowerton Baltimore MD 21229 Hortense 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State permit. Pages 1
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Importent: If itel
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State NODdlawn 03.05.05 Noodlawn, 4 □ Donation 5 □ Other (Specify) 21. Signa are of Fundal Service License 22. Name and Address of Facility
Vaughn C. Greene Funeral Services
5151-Baltimore National Pike Baltimore MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GRAM NEGATIVE SEPSIS Physician /Medical Due to (or as a consequence of): Examiner TRACT INFECTION URINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit MEDICAL EXAMINE Due to (or as a consequence of) O PATER THE A APPROVED BY Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þý EREBRAL VASCULAR ACCIDENT 1 Ves 2 No 3 Probably 4 Unknown Be Completed Cervical stenosis with complications 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Vithin 24 hours after death.

To the Funerel Director: Af 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 28,2005 RES 000 Drumbut, M.B.B.S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DARSHANA PUROHIT, SINAI HOSPITAL OF BALTIMORE 31. Date filed (Month, Day, Year) MAR 0 4 2005 32 degistrar's Signature State food Registrar

		•	, FOI	partment of Health and M <i>ertificate of Death</i>	ental Hygiei Reg.	ZIIII5 0721.7
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		Walter S. Staniewski		02/28/20	005 10:05P M
/	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			703 S. Lakewood Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Baltimore Baltimore If Under 1 Year If Under 24 Hrs.	8 Date of Birth	N/A 9. Birthplace (State or Foreign
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	ъ		Usual Residence of Decedent			
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	the M	ecto	Maryland N/A Baltimor	10f. Zip Code	100	Citizen of What Country?
	3a or	Funeral Director	703 S. Lakewood Avenue	21224		ted States
	death ms 2	nera		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - American Indian,
9	or ite	/Fu	1 Never Married 2 Married 1 Ves 2 No	1 ☐ Yes 2 ☑ No Specify:	riloan, etc./	Black, White, etc.
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pu	be filed within 72 hours after death with the Maryland stal Hygiene. id other then "neturel", or items 23a or 28e-f show event, the Medical Examinat must be notified at	ВеС	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Sumame)
yla	should tund Ment	2	Stephen Staniewski	Anna Byo	-	
Maryland	12 sh h and 7 is n treun	171		ailing Address (Street and Number or Rura S. Lakewood Avenue		· · · ·
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Importent: If item 27 is marked other than "neturel; or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examiner must be rediffied at once.		1 □ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 ★Other (Specify) Examples of St. Stan	riematory or other place) uislaus Cemetery 03/	05/05 Bal	timore Maryland
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siol	tendir eath. or: Af the fu	catic	2 Accident investigation	M 1 Tes 2 No		
Σ	or At after d Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, St	and Number or Rural Route Number, ate)
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	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or and manner stated.			
	To the To the Comp	Ž	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
	X		> XV -w)	D 24276	-	3 3 0,5
	101		30. Name and address of person who completed cause of death (Item 23a) (Typ	De, Print)) 7	1214
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			1 - State of Maryland / Department	ent of Health and Me ate of Death	ental Hygien Reg. N	711113	07248
	Physici		1. Decedent's Name (First, Middle, Last) Robert Spore		2. Date of Death Month D	J JOOS	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. Ci Univer Sity of Mary lad Modical Cut	s Days Hours Min.	3. Date of Birth (Month, Day, Year	County of Death	place (State or Foreign ntry)
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	3a or 2		10e. Street and Number 400 Riverside Drive	Zip Code 21122	10g. C	itizen of What Cour USA	ntry ?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event. The Medical Evantinar must be ricillised at Once.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. If Yes, s	cedent of Hispanic Origin? (Spec pecify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
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Physician
/Medical
Examiner

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760.

Registrar DHMH 17 Rev 1/2001

Physici		1. Decedent's Name (First, Middle, Last) Charles K. Smith SR.			Day Yeer	3. Time of Death 3:49 0 M				
/Medic Examin		4a. Facility Name (If not institution, give street and number) North Grund Lospital	4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Gru	nde				
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 01/11/19	9. Birthpl Count	ece (State or Foreign ry) MD				
ith the Maryland or 28s-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo MD Anne Arundel Pasader			10	od. Inside City Limits 1 ☐ Yes 2 🕱 Ño				
th with th 23s or 28	i Director	10e. Street and Number 8482 Rugby Road	10f. Zip Code 21122		Citizen of What Count	ry?				
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene 1 hours important: if item 27 is marked other than "natural; any injury or other traumatic svent, the Medical Exones.	To Be Co	17. Father's Name (First, Middle, Last) Charles Warren Smith	uipment Operato 18. Mother's Name Eve Sn	First, Middle, Maid	BGE en Sumame)					
d 2 shouth and N			g Address (Street and Number or Aura Barcelona St.,							
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permi Depa Impo any it			59 Riviera Driv	re, Pasad						
Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. NOUMON(A) Lue to (or as a consequence of):	or the mode of cyring, such as calculated	or respiratory arrest,		Interval Between Onset and Death				
be executed be executed cian and purial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Under, in: Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			10	S years				
the death certificate be executed by the attending physician and tched for use as the burial-transit	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year				
w requires that the deben signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown					
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to	Completed			24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of				
hysiciar nis certif I directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Impatient 2 ☐ ER/Outpatient	Other	me 5 Residence	6 □Other (Specify)					
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To the Hospital or Attending Physician: The taw within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streeth building, etc. (Specify)	,	City or Town, Sta						
he Hospin 24 hospin 24 hospin 54 hos	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death (Check only one) Certifying Physician: To the best of my knowledge, death (Check only one) Medical Examiner: On the basis of examination and/or invalid	(s) and manner as sta nd place, and due to t	ted. he cause(s)						
Tot Tot com	2	29b. Signature and title of certifier Sturm Jarob MD	29c. License number 00022483	29d. C	March 2, 2005					
67		30. Name and address of person who completed cause of death (Item 23a) (Type, I ST VOTT JACOBS MD 305 Nospital	Dr. Glan Burni	د, mp ع	2106					
Sta Registr HMH 17 Rev 1/20	ar	31. Date filed (Month, Day, Year) 32. Registrar's Signature ORIGINA	DOCAZ423 Print) Dr. Glen Burni							
		Of Harry								

MARCH

SCHIMINSKY

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 0005 M MARIE H. STRATMANN 01 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner f Under 1 Year If Under 24 Hrs. Anoths Days Hours Min. (Mor 900 caton BALTIMORE CITY Aue 8. Date of Birth (Month, Day, Year) Nov. 19,1909 5. Social Security Number If Under 1 7. Age (In vrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign Country) Months 1 M 20XF 95 213-38-2451 Director Marýland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a, State 10d. Inside City Limits 28a-f ahow ns 23a or 28a-f ahov Completed by Funeral Director 1 ☐ Yes 2 X No Catonsville - Baltimore County Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 21228 USA 717 Maiden Choice Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status traumatic avant, the Medical Examiner filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Montgomery Co. Board Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) of Education Principal 12 yrs. 8 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) in and 2 should be fill Health and Mental H tam 27 is marked oth Be George F. Stratmann Elise Riemenschneider ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health itam 27 i 12470 Barnard Way West Friendship, Md. 21794 Gretchen S. Wright (Niece) othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department o Important: If any injury or Parkwood Cemetery 3-4-2005 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Lassann funeral Home 6.3. · Lassahr 7401 Belair Rd. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician NEUMONIA disease or condition resulting in death) ONE NEEK /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physiclan/Medical Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 5 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funaral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hc To tha Fun completely i

Hospital or Attanding Physician:

S'TRATIMINI, MINRI

State Registrar

31. Date filed 44 P. D. 4 Par 2005

29b. Signature and title of certifier

(Check only one)

M.O.

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

MAR 012005

CHANDRAS. BOMMA, M.D. ST AGNES HOSPITAL GOO CATEN AVENUE BALTIMURE

Physici	an	1. Dec	or Amend Item egistrar AMEND ITE edent's Name (First, Middle,	Last)	3						2.	Month	ath Da	у	Year	3. Time of Death
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Funeral Director		.2	Sex 7. 4 1 XM 2 ☐ F	Age (In yrs. last birthday Yrs.			te of Birth onth, Day, Year)	9. Birthplace (State or F Country)
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80589		23a. Part1. Enter the disease, or co	accalmi			Road - Ki	ngsville	e, Maryland 21
	edical Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Mitral Due to (or o	as a consequence of): Valve Prola as a consequence of): as a consequence of):	pse			
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 tat time of death 5	□Ectopic pregnancy □ Other (specify)		2	3d. Date of delivery Month Day Yea
signed by	by	Part II. Dther significant conditions	contributing to death	but not resulting in the	underlying cause given in F	Part I. 23	1	se contribute to the cause of deal
e law requ has been je 2 shoul	Completed						la. Was an autopsy performed?	24b. Were autopsy findings ava prior to completion of caus death? 1 AYes 2 □ No
sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.1	Place of Death (Chec		
y Phys er this eral di	٦. ٦	XXYes 2 No 27. Manner of Death	28a. Date of Ir	njury 28b. Time	ent 3L DOA 41	Nursing Home 5	☐ Residence 6 escribe how injury	
ttending F death. stor: After r the funer.	ation	1 Natural 5 Pending 2 Accident investigate		Day Year) Injury	Work? M 1 ☐ Yes			
l or Atter after des Director I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of	Injury - At home, farm, s etc. (Specify)	treet, factory, office	28f. Lo	cation (Street and ty or Town, State)	l Number or Rural Route Number
m = 73			Physician: To the be	st of my knowledge, dea	th occurred at the time, da	te and place, and du , death occurred at the	e to the cause(s) a	and manner as stated. place, and due to the cause(s)
Hosp 4 hou Fune (ely fill		29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	aminer: On the basis and manner	stated.				
	Medical C	(Check only 2 Medical Ex	aminer: On the basis	stated.	29c. License num OCME		29d. Date	e signed (Month, Day, Year)
Hosp 4 hou Fune ely fill		(Check only 2 Medical Exitation one) 29b. Signature and title of certifier	aminer: On the basis and manner Hall a o completed cause o	stated.	29c. License num OCME	ber	29d. Date	

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of I			iene eg. No2 () () 5	07251
	Physici		1. Decedent's Name (First, Middle, Las Alice Christina	-7				2. Date of Deat Month February		3. Time of Death 10:30 AM
	/Medi Examir		4a. Facility Name (If not institution, given 5 Neves Court	street and number)		4b. City, Town, o	or Location of Dea		4c. County of Dea Baltimo	th
	Funeral Director		213 32 322	ex 7. Ag □ M 2 □ X 0 F	ge (In yrs. last birthday 83 Yrs.	Months Days			9. Bir 922 M	thplace (State or Foreign ountry) aryland
	e Maryland Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Baltimo	re	10c. City, Town or L Baltimo	re				10d. Inside City Limits 1 ☐ Yes 2€ No
	3a or 2		10e. Street and Number 5 Neves Court			10f. Zip Code 212	234	1	0g. Citizen of What Co	ountry?
9600	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinat must be routiled at	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🛣 No	Specify:	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, Whit Specify: W	e, etc. nite
21215-0036	od within 72 giene. er than "nat the Medica	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or	(Give	edent's Usual Occup is kind of work done DO NOT use retire	during most of w	orking	16b. Kind of Business Retail	/Industry
and	2 should be filled within and Mental Hygiene. Is marked other than aumatic event, the Ms	To Be (17. Father's Name (First, Middle, Last) Eugene Leroy 0					ame <i>(First, Middle, M</i> na Fern Ta	,	
Maryland	12 should be h and Mental 7 is marked o traumatic eve	Ė	19a. Informant's Name/Relationship (Type, Print)			and Number or F	Rural Route Number,	City or Town, State, 2	
	Pages 1 and 2 nent of Health int: If item 27 inty or other tra		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 □		20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	сө)	Date	20c. Location - City or	Town, State
Baltimore,	permit. Pages Department of Important: If ii any injury or once.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Pyneral Service Licen	<i>(</i>)		ash. Crem			Laurel, Ma	aryland al Home Inc.
B	8 2 E 8 8		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused		6415 Bela	ir Road	Baltimore	, Maryland	
8760,	Physician /Medical Examiner und physician and this private and the private and	dicai Examiner	snock, or near failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as Due to (or as Due to (or as Due to (or as Due to (or as	disc	Meigh		Interval Between Onset and Death		
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc	у		23d. Date of dei Month	ivery Day Year
۵.	w requires that been signed b should be deta	þ	Part II. Other significant conditions c	ontributing to death b	out not resulting in the o	inderlying cause giv	ven in Part I.		pacco use contribute to	the cause of death?
Vital Records,		Completed						24a. Was ar autops perform 1 \(\text{Yes} \) 2		topsy findings available completion of cause of
	icien: certific rector,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	0 CC CC/O-+	ot action of	or	eath Check onl one		
ion of	ing After une	H ,	1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time o	of 28c. Injur	v at	28d. Describe ho	nce 6 ⊡Other (Spe w injury occurred	cify)
Division	or A fiter Direction by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	edicai (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best liner: On the basis o and manner st	of my knowledge, dea f examination and/or in ated.	h occurred at the tire vestigation, in my o	me, date and place opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		M	29c. Licens	e number	29	Od. Date signed (Monti	n, Day, Year)
ĺ	0	1	30. Name and address of person who	completed cause of d	leath (Item 23a) (Type	Print) 4/2/2 #	3 Fre	T hon	ARd S	21236
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 4 20	32 Registr	ar's Signature	ale	J CF131	Supplies		1000

			1- For Amend Item 26 State of Maryland (Department of Health and Mental Registrar Certificate of Death	Hygien	e •2005	07255
	Physicia		Arlen Mardell Thomas	of Death	ay Year	3. Time of Death 2:28 PM
	/Medic Examin		4a. Facility Name (If not institution, give-street and number) 4b. City, Town, or Location of Death		c. County of Death	to.
	Funeral Director		5. Social Security Number 5. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 1 Usual Residence of Decedent	of Birth th, Day, Year	37 g. Birth	place (State or Foreign htry)
	the Maryland 28a-f show	tor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	death with the Maryland rms 23a or 28a-f show request the multified at	ai Director	10e. Street and Number 107. Zip Code 21136	10g. C	itizen of What Cou	ntry?
	after or Ite	by Funerai	3 Widowed 4 Divorced Year or Dates:	or No-	14. Race - Ameri Black, White Specify:	
21215-0036	d within 72 hours giene. ar than "natural", . Iha Medical Exal.	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12	16b. I	Kind of Business/Ir OHO. CU	UNHU
Maryland	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, thank	To Be C	17. Father's 'Name (First, Middle, Last)	Middle, Maide	n Sumame) HOMOS	J
	1 and 2 sho Health and I tem 27 la ma other traume		19a. Informant's Name/Relationship (Type, Print), 19b. Mailing Address (Street and Number or Rural Route / 2706 The Alameda BOH)	o, MD	or Town, State, Zi	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 21 2 05	- Pik	cesville,	own, State
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rughn C 8728 Luberty Rd. Pand	Green 2115to	wy MO	21133
	Physician		23a. Part1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition	tory arrest,	m	Approximate Interval Between Onset and Death
,760,	/Medical Examiner hysician and the burial-transit	licai Examiner	d	in le	les	
O. Box 68	that the death certificate ed by the attending phys detached for use as the	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deliv Month	ery Day Year
ds, P.O	og og	by	Ather colembia VALLE Ditent	. Did tobacco	_	he cause of death?
I Records,	has b	Completed	24a.	. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
Vital	ilcian: certific rector,	Be	25. Was case referred to medical examiner?		6 ∏Other (Speci	fv)
ion of	Jing After fune	ation: To	27. Manner of Death 1	cribe how inju		
Division	i Pite	Certification:	3 Suicide 4 Homicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ation (Street a or Town, Star	und Number or Run te)	al Route Number,
	the Hospital hin 24 hours the Funeral I he Funeral I npletely filled	Medicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	time, date ar	nd place, and due t	o the cause(s)
	To t To t	Σ			ate signed (Month,	Dey, Year)
			30. Name and address of person who completed duse of death (Item 23a) (Type, Print) Nicol my Division Univ Man Luni Balton	<u></u>	mp	
1	Sta Registi		31. Date filed (Month, Buly, Year) 32. Registrar's Signature	-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. < 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Janlor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Maris Baltimore at Merci If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age #n yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 MM 2□ F Months Days Hours Min. 53 Yrs. 218·58·7118 MD Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Exeminer must be notified at Baltimore Director 1 X Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 or items 23a 1100 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Specify: 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Associate 2tharage N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James laylor Dhella 19a. Informant's Name/Parionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crawford Sister Oakhaven Woodlawn MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, MD eenmount 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Cremation Services 56 Baltimore National BaltimoreMD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Immo deficience sicol /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 - No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence & Other (Specify) has pice 2 1 Yes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5408.54 2005 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 301 Riseberg 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar MAR 0 4 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician 2005 5:00 PM Taylor Marlene /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pasadena Anne Arundel 300 North Carolina Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 04 1931 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🖫 F 219-28-7090 Director 73 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "naturet", or items 23e or 28e-f ehow other treumstic event, the Medical Examiner must be redified at 1 ☐ Yes 2 ☒ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 North Carolina Avenue 21122 USA Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be fill and Mental H Be Edmond Rauchhaus Dorothy Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an ent: If item 27 Is n 300 North Carolina Avenue, Pasadena, MD 21122 Robert M. Taylor Sr. (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 03 20c. Location - City or Town, State permit. Pages
Department of I
Importent: If it
eny injury or or
once. 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 2005 * 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery Crownsville, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 or complications that havesed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one had each line. 23a. Part1 Enter the disasse, or conshock, or heart failural List only Approximate Interval Between Onset and Death tre B Immediate Cause (Final disease or condition resulting in death) nan **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Month Year 5 Other (specify) 4□Pregnant at time of death 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 24a. Was an autopsy certificate 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2) Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this 28b. Time of Injury Manner of Deat 28d. Describe how injury occurred Hospitel or Attending 1 Natural 5 Pending death. investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ze, completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Cochrau Dr. 31. Date filed (Month, Day, Year) 32. Registrar Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			S	ate of Mary		epartment of Certificate o		Mental Hy	20	05 07050
			Decedent's Nerge (First, Middle, Last)		•	/	Death	2. Date of De	Reg. No.	3. Time of Death
	Physicia	-	William			Thon	pson	Month	2 Bay	Year 2005 8=00 Am
1	/Medica Examine		4a Facility Name (If not institution, give stree	t end number)	1	0	4b. City, Town, or	Location of Deat	h 4c. County	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7
			Cromwell Nue.	sine,	Hom	2	Bill	himore		`IMORE
	Funeral Director		5. Social Security Number 6. Sex 1219-18-6628		yrs. lest birth Y	day) If Under 1 Ye Months Day			th ey, Year) 923	9. Birthplace (State or Foreign Country) MARYLAND
	ylend	- H	Usuel Residence of Decedent 10a. Stete 10b. County	100	c. City, Town	or Location				10d. Inside City Limits
	Sa-fal	ig	MD BALTIMORE		rowson					1 □ Yes 2 □XNo
	ath with the Marylen (23e or 28a-f show	Director	10e. Street end Number 8410 LOCH RAVEN BLVI).		10f. Zip Code 2128	_		10g. Citizen of V USA	What Country?
	terns 23e	Funeral	11 Marital Status 12. V	Vas Decedent Ever	in U,S.	13. Was Decedent of If Yes, specify C		Specify Yes or No		e - American Indian,
Maryland 21215-0020	urs af	2	1 ☐ Never Married 2 ☐ Married	Armed Forces?	II	1 □ Yes 2 □ N		orto Hican, etc.)	Specify	ck, White, etc. WHITE
2-0	n 72 hours	Completed	15. Decedent's Education (Specify only highest grade columns)	n mpleted)	1	Decedent's Usual Occ Give kind of work do	ne during most of w	orking	16b. Kind of Bu	usiness/Industry
12	within then.	ğ		College (1-4or 5+)		ife. DO NOT use ret •R.S.	ired)		REVENUE	OFFICER
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lan	ould be Menfai arked c	o Be	ROBERT THOMPSON				LORETTA	A CAMPBEI	LL	
ary	2 should and Men is marke aumatic		19a. Informent's Name/Relationship (Type, I	Print)	19b.	Mailing Address (Stre				Stete, Zip Code)
Z .	alth alth	1	LOUISE THOMPSON/WIFE			10 LOCH RA				1286
ore	ges 1 ges 1		20a. Method of Disposition 1 1 Burial 2 ☐ Cremation 3 ☐ Remo		cemetery	Disposition (Name of , crematory or other p V VATTEV N	olace)	Date		City or Town, State
Baltimore,	t. Perturnant:	1	4 ☐ Donation 5 ☐ Other (Specify)		JOLAIVE	Y VALLEY N				VILLE, MD AL HOOME, P.A.
Ba	permit. Peges 'Department of Firmportant: if Ite any injury or of ph.c.		21. Signature of Funeral Service Licensee	up	1	8521 LOCH	H RAVEN BI	LVD. TOWS	SON, MD	21286
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the use on each line.	deeth. Do no	t enter the mode of o	dying, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final		nini	imoni	Tu			oned and sour
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8760,			Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury							
687	ficete p phys	Physician/Medical	that initieted events resulting in deeth) Last	Due	to (or as e co	nsequence of):				
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	death	SICIS	Part II. Other significant conditions contribu	ting to death but no	t resulting in	the underlying cause	given in Part I.	23b. Did	tobacco use cor	ntribute to the cause of death?
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ds,	g 552 .	ام						24a. Wes	en eutopsy	24b. Were autopsy findings
Records,	w require been si should	Completed			<u>.</u>			perf	ormed?	available prior to completion of cause of death?
æ	The lew ate has b page 2 s	E C						10	Yes 27 No	1 ☐ Yes 2 ☐ No
Vital	iclan: The certificate irector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	eath (Check only	one)	
of <	Q 0. 7	2	1 Yes 2 → No Hosp	1 🗆 Inpatient	2 ER/Out	patient 3 DOA		Home 5 ☐ Res		
n o	Ing Ph	on:		Ba. Date of Injury (Month, Dey Yea	28b. Ti		njuryat Vork? □ Yes 2 □ No	28d. Describe	how injury occurr	red
Division	or Attending ster death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	Be. Plece of Injury - building, etc. (S)	At home, fare	n, street, factory, offic		28f. Location (City or To	Street and Numb wn, Stete)	per or Rural Route Number,
_		edical Ce	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:							
	To the Within To the compl	ŝ	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date signed	d (Month, Dey, Year)
	, , , ,		1 Galler	jury		De	059853		Mar.	3rd, 2005
	HY		30. Name and address of person who comple	ted cause of deeth	/ /	, ,	0	0/ 1	0 1	3rd, 2005 Timore 2/239
	1 \		Winglin Guo, 1	nu 3	5601	Loch	Kaven	DIVA	104/1	more 2/259.
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's S	oignature *					
DHI	MH 16 Rev 6/95		MAR 0	2005	Coases -	HI	ad)			
				are "	The state of the s	J. Apa	W.			

			For Stete Registrar	State of Ma	-	-	ment of H		ind Me	ental H	ygier Reg. 1	-20	05	0.7	250
	0.		1. Decedent's Name (First, Middle, Last)							2. Date of D	eath		V	3. Time o	f Death
	Physici /Medic		Donald Peter Toole						N	larch		2005	Year	1:11	P M
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b	. City, Town, or	Location of	f Death			4c. County	of Death		
			11809 Enid Drive	7 4	da una landala		otomac Under 1 Year	If Under 2	74 Uro			Montg	omery		
	Funeral Director		5. Social Security Number 6. Sex 1対 196-22-7327	M 2□F	(In yrs. last bir 74		onths Days	Hours	Min	8. Date of B (Month, L May 6	Tay Yes	30	9. Birthp Coun Penn:	lace (State try) sylvar	o <i>r Foreign</i> nia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Locatio	on .						1	0d. Inside C	ity Limits
	f sho	ō													2X No
	28a-	Director	Maryland Montgomer 10e. Street and Number	У	Potoma		Of. Zip Code	·			10g.	Citizen of	What Cour	itry?	
	h with	a Di	11809 Enid Drive				20854						State	,	
	deat	Funeral	11. Marital Status	2. Was Decedent E Armed Forces?	ver in U.S.	13. Was	Decedent of Hi s, specify Cuba	spanic Orig	gin? (Spec	cify Yes or N	10-		e - Americ		
Maryland 21215-0036	s within 72 hours after death with the Maryland liene. I than "natural", or tlems 23a or 28e-f show It e Medical Exemples must be notified at	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 K Yes 2 □ N If Yes, Give Year or Dates: K			Yes 2K No	Specify:	, Fuelto F	noan, etc.)			^{ck, White,} ^{y:} Whi		
5-0	72 ho	Completed	15. Decedent's Educi (Specify only highest grade	ation completed)	16a.	Decedent'	s Usual Occupa	ation Jurina most	of workin	ıa			usiness/Ind		
2		mple	Elementary/Secondary (0-12)	College (1-4or 5	+) M	life. DO I	VOT use retired,)	or working	9			nacue: npany	tical	
2	e filed within Il Hygiene. other than vent, the Mo		17. Father's Name (First, Middle, Last)	4	MI	arket	ing Man		r'a Nama	(First, Midd	la Adaid				
anc	2 should be fil and Mental H Is marked ott Burnatic even) Be	John V. Toole, Sr.							onne1		en Suman	ne)		
Z	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (Typ	e. Print)	19b	. Mailing A	ddress (Street a					v or Town	State 7in	Code)	
E S	nd 2 salth ar		Dorothy R. Toole/W		1		Enid Dr						2085		
J.	s 1 a of Hez item othe	1	20a. Method of Disposition		20b. Place of	f Disposition	n (Name of ry or other place	a) M	arch	ate ₇	20c.	Location	City or To	wn, State	
Ē	Page nent c snt: If		1 🖾 Burial 2 □ Cremation 3 □ Re 1 4 □ Donation 5 □ Other (Specify)	moval from State		-	Cemeter		200	-	Gen	mant	own,	Mary1	and
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event. ODGe.		21. Signature of Funeral Service Licence			22. Na	me and Addres	s of Facility	300	rt A.	Tun	phre	y Fun	eral	Home/
	205 9		moral.		01353	Rock	kville,	Mary.	Land	20850	-280	55	Ly 210	CHUC	
п			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each lin	the death. Do r e.	not enter th	e mode of dying	g, such as o	cardiac or	respiratory	arrest,			Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Periphe			Diseas	е						Orisot und	
	Examiner		1	Due to (or as a	consequence	of):									
		ler	Sequentially list conditions, and the sequential sequen	Dua to (or tax a	consequence	of):							-		
V	cuted nd ransit	Examine	that initiated events c.												
>,0928	death certificate be executed e attending physician and infor use as the burial-transit		resulting in death) Last	Due to (or as a	consequence	of):									
	icate b physic the b	dical	d.												
9 X	eath certific attending p for use as t	Physician/Medi	IF FEMALE: 23	c. If yes, outcome	of pregnancy							20.1.0			
Вох	atten I for u	cian	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		opic pregnancy ner (specify)						te of delive onth	-	Year
0	at the de by the tached	hysi	9 Unknown	9□ Unknown											
s, P	The law requires that the tte has been signed by thoage 2 should be detache	by P	Part II. Other significant conditions cont		it not resulting in	n the under	lying cause give	en in Part I.		23e. Dic	tobacc	o use con	ribute to th	e cause of	death?
of Vital Records,	w require been si	ted	Chronic Renal Fai	Lure	<u> </u>					1] Yes	2 🕅 No	3 🗌 Prob	ably 4 🗌	Unknown
ecc	elawr has be je 2 sh	Completed								24a. Wa	s an	24b.	Were autop	psy findings	available cause of
E H		Cou								per 1 ☐ Yes	formed 2X I		death? 1 □ Yes	2□ No	
Vite	Physician: This certificated director, p	Be	25. Was case referred to medical examiner?	spital:			Othe			Check on					
	Phys r this ral dii	.: To	1 X Yes 2 No Proceed No. 27. Manner of Death	1 ☐ Inpatie	nt 2 ☐ ER/Ou v 28b. 1	utpatient 3 Time of	DOA Othe	4 🗆 1401		ne 5X Re 8d. Describe				/)	
on	Attanding r death. ector: After by the funer	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury	28c. Injury Work	(? /es 2 □ N		04. 2000.12	371011 11	jury occur	.00		
Division		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	iry - At home, fa . (Specify)	arm, street,	factory, office		2	8f. Location City or T	(Street	and Numb	er or Rura	l Route Nun	nber,
	Hospital or 24 hours afte Funeral Dis tely filled in		200 Continue 4 X Continue Physic	siam. To the best o	d must be avide des					() ()					
	Hos Hos Fur	edical	29a. Certifier 1 2 Certifying Physic (Check only one) 2 ☐ Madical Exemin	er: On the basis of and manner sta	examination an	e, death occ nd/or investi	igation, in my op	e, date and pinion, deat	d place, a th occurre	nd due to the d at the time	e cause e, date a	(s) and maind place,	anner as st and due to	ated. the cause(s	s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29c. License	number			29d. [Date signe	d (Month, i	Day, Year)	
	F > F 0		Peter San	Ja			D2439	98			Mar	ch 3,	2005	5	
	KXI		30. Name and address of person who cor												
	0		Phillip J. Schwartz					.d. #3	302,	Rockv	ille	, Mai	cylan	d 2085	50
	Sta		31. Date filed (Month, Day, Year) MAR 0 4 200	32. Registra	r's Signature	44									
DI	Registi	5 6	MAR U 4 200	Mesen	· K	dos	R)								
DH	IMH 17 Rev 1/2	001				-									

ORIGINAL

			State of Maryland	-	rtment tificate			nd Me	ntal Hyg	giene	2005	07060
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate	or D	eatn_	2	. Date of Dea	Reg. No.	-000	3. Time of Death
	Physicia /Medic		Eugene Tovey						Month	Day	5, 200!	
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, To	own, or L	ocation of			_	County of De	
			13765 Bottom Road			Hyd					Baltim	
	Funeral Director		5. Social Security Number 212-50-0249 6. Sex 7. Age (In yrs. last 57	st birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min. 8	. Date of Birth (Month, Day 9 / 11 / 1	y Year) 947		rthplace (State or Foreign Country) arvland
	D		Usual Residence of Decedent						-,, -			
	shov	7		Town or Loc Hydes	ation							10d. Inside City Limits 1 ☐ Yes 2∕XNo
	28a-f	Director	10e. Street and Number		10f. Zip C	code				10a Citi	izen of What C	
	h with	DIE	13765 Bottom Road			210	82				U.S.A.	
	ems?	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13, V	Vas Deceder Yes, specifi	nt of Hisp v Cuban.	panic Orig Mexican.	in? (Specif	fy Yes or No- can, etc.)		14. Race - Am Black, Wh	
5	should be filed within 72 hours after death with the Maryland and Mental Hyglene. Inakted other than "neturel", or items 23e or 28e-f show imarted other than "neturel", or items 23e or 28e-f show imartic svent, the Medical Examinar must be notified at	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 1 No If Yes, Give 3 □ Widowed 4 1 □ Divorced Year or Dates:		☐Yes 2		Specify:					hite
3	2 hou		15. Decedent's Education	16a. Deced				-	1	16b. Ki	ind of Busines	
7	thin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. E	kind of work OO NOT use	done du retired)	ring most	of working				•
7	led wi lygien her th		12	Iron	Work						cal 16	
2	d be fi	Be c	17. Father's Name (First, Middle, Last) James Tovey			,		s Name (F	First, Middle,	Maiden	Surname)	
<u> </u>	shout nd Me mark	္	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street an				r, City o	r Town, State,	Zip Code)
, Mc	s 1 and 2 should be filed within 72 hours after death with the Marylan if Healint and Mental Hygiene. If Healint and Mental Hygiene is the first 73 is marked other than "neturel", or items 23e or 28e-1 show other treumatic svent, the Medical Examiner must be notified at		Mary Gates	10765	Bott	om R	Road	Hyde	s, MD	210	082	
ב כ	of He If itsm or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Pla	ce of Dispos netery, crem	sition (Name atory or oth	of er place)		Dat	е	20c. Lo	cation - City o	r Town, State
Dallillor	t. Pag rtment rtant: njury		`4 □Donation 5 □Other (Specify) Balt	o./Wa				3/3/0				aryland
<u>8</u>	permit. Pages 1 and 2 Department of Health a Important: if itsm 27 is any injury or other tree snce.		21. Signature of Funeral Service Licensee	Br 31	adley 24 Wi	-Ash	ton-l	Matth	ews Fu	nera	al Home	i, Inc. 21222
	time.		23a Part 1. Enter the disease, or complications that caused the death. shock, or leart failure. List only one cause on each line.								ark, in	Approximate Interval Between
•	Physician		Immediate Cause (Final disease or condition	er	leer	Q.						Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a conseque	nce of):		0						1 - j
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseque	nce of):								
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c						_			
0/00,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or as a conseque	nce of):								
000		edical	d									
Š	death certif e attending ed for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant							2	23d. Date of de	elivery
0	The law requires that the death certif rate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pred Other (spec						Month	Day Year
<u>.</u>	that the		9 Unknown Part II. Other significant conditions contributing to death but not result	ing in the un	derlying cau	ise diven	in Part I		23e Did to	bacco u	ise contribute	to the cause of death?
cords,	The law requires that the ate has been signed by th page 2 should be detache	d by				.00 g.v.o.,			1 5 2			robably 4 Unknown
ວ ວ	s beer 2 shou	plete							24a. Was a		24b. Were a	utopsy findings available
ř	The I	Completed							autops perfor		prior to death?	completion of cause of s 2 XNo
	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					of Death (C	Check only or			
5	Physicien: this certificated director.	. To		R/Outpatient		Other:	4 🗀 1901		5 Resid		6 Other (Spe	ecify)
SION	th. : After	itlon	1 Natural 5 ☐ Pending (Month, Day Year) 2 Accident investigation	Injury	М	Work?	s 2⊡N		J. Describe fi	ow injur	y occurred	
<u> </u>	r Atter er dea rector by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory,	office		28f	Location (S City or Tow	treet and	d Number or F	Rural Route Number,
5	itel ours aft rei Di		,									
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowl and manner stated.	edge, death n and/or inv	occurred at estigation, in	the time n my opir	, date and nion, death	place, and occurred	d due to the c at the time, c	ause(s) late and	and manner a place, and du	s stated. e to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier		29c. l	License r	number	_	2	9d. Dat	e signed (Mon	th, Day, Year)
	1		(M.)		1	118	48	7		2/	2405	
1	0		30. Name and address of person who completed cause of death (Item 2 NYO TITA NT BILLY SAN 31. Date filed (Month, Day, Year) 32. Registrar's Signatu	3a) (Type, F	Print)	RU	Ē i	BAL	TO. N	1 D.	2123	6
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signatu	re 🥒	. M		-					
	Registr	ar	MAD 0 4 2005 Believe B	Liga	cer							

			1 - For State Registrer	ate of Marylan		artment of H			iene 2 0 0 5	07261
	Physici /Medio			ALKER				2. Date of Deal Month	h Day Year 28 200	3. Time of Death S 0250 M
	Examir	ier	4a. Facility Name (If not institution, give street Mercy Medical 5. Social Security Number 6. Sex	Center		Baltin	Location of Death Ore If Under 24 Hrs.	/ Date of Birth	Baltimore	city
	Funeral Director		5. Social Securify Number 6. Sex 213 36 5775 Social Residence of Decedent	7. Age (In yrs.)	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day AUG •	5,1940 M	thplace (State or Foreign Dunity) ARYLAND
	e Maryland la-f show	ctor	MD . 10b. County N/A		y, Town or Lo BALTI					10d. Inside City Limits 1 ↑ Yes 2 No
	ath with the 23a or 28	rai Director	10e. Street and Number 1121 WEBB COURT				202		0g. Citizen of What Co	FA.
920	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show iteal Examinat must be rediffed at	by Funeral	1 Never Married 2 Married 1	as D <i>ec</i> edent Ever in U. med Forces? □ Yes 2 X No Yes, Give X ear or Dates:		Was Decedent of Hi f Yes, specify Cuba t □ Yes 2X No	Spanic Origin? (Sp n, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: BL	e etc
21215-0036	within ane. than	Completed		pleted) ollege (1-4or 5+) NOWN	(Give life. l	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work)	ring	16b. Kind of Business	·
Maryland 2	be filed at othe event,	To Be Co	17. Father's Name (First, Middle, Last) RILEY WALKER, SR.	NOWIN	позг	IIAU IL	18. Mother's Nam	e (First, Middle, M		Ь
	nd 2 lith a 27 is r tra	•	19a. Informant's Name/Relationship (Type, P MERLE SMITH (NIEC	Ε)	3319	FIELDV	IEW RD.	BALTIM	City or Town, State, A	LAND 21207
altimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 12 Burial 2 Cremation 3 Remov 4 Donation 5 Other (Specify) 21 Strature of Fundamental Strature	al from State MT	· ZTÖ	sition (Name of natory or other plac N CEMET	ERY 3/7		20c. Location - City or ANSDOWNE	Town, State , MARYLAND
Ba	permit. Departr Imports any inji	4	LEWIS 23a. Part1. Enter the disease, or complication	F. GWYNN	L	4 -	GWYNN I		HOME 21	215-6393 • /Approximate
	Physician /Medical		shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	06	Ineting !				Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequ	uence of):					
8760,	ate be executed hysicien and the burial-transit	cai Examiner	that initiated events	Due to (or as a consequ	uence of):					
Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	yes, outcome of pregna Live birth 2 Fetal Pregnant at time of de Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ds, P.O	uires that the signed by the detaction of the detaction of the detaction of the detaction of the sign	by	Part II. Other significant conditions contribut Calhama Hyp		_				pacco use contribute to	the cause of death?
of Vital Records,	The law requir ate has been si page 2 should l	Completed						24a. Was ar autops perforn 1 \sum Yes 2	y prior to c	itopsy findings available completion of cause of
of Vital	Physician: T this certifical ral director, p	To Be C	25. Was case referred I medical examiner? 1 Yes 2 No Hospit	1 Inpatient 2 1	ER/Outpatien		4 Nulsing no	h (Check only on	V	
Division o	tending death. tor: After the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28	a. Date of Injury (Month, Day Year) a. Place of Injury - At ho			res 2□No		reet and Number or Ru	ıral Route Number,
Ö	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by		29a. Certifier 1 Certifying Physician	building, etc. (Specify	wledge, death	occurred at the tim	e, date and place,	City or Town	use(s) and manner as	stated.
	To the He within 24 To the Fu	Medical		in the basis of examinat nd manner stated.	tion and/or inv	29c. License			ate and place, and due	
	$\langle \cdot \rangle$		30. Name and address of person who complete	ed cause of death (Item	23a) (Type,	10 / 1	7667	(February.	28 2005
	Sta	te.	31. Date filed (Month, Day, Year)	32 Aegistrar's Signat			MO 21	201.		7.1
	Registi		MAR 0 4 2005	Status L	F Ago	sel.				

	<u>.</u>		For State Registrar	State of Maryland / I		artment of Hetificate of L			giene Reg. No.	05	072	62
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last Annie Mae 4a. Facility Name (If not institution, give	Williams		4b. City, Town, or	Location of Do	2. Date of De Month	Day	2005 unty of Death	3. Time of 2 30	Death A M
	Funeral	ier	St. MENES MENUTUC 5. Social Security Number 6. Se	ALE		BACTIME If Under 1 Year Months Days		Irs. 8. Date of Bir		N/	A place (State ontry)	r Foreign
	Director wode ###	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Lo	cation	re)	03. [(). 1914 		Od. Inside Ci	•
	th with the N 23e or 28a-f	ai Director	10e. Street and Number 3109 Presbury	Street		10f. Zip Code	214		10g. Citizen	of What Cour		20110
980	within 72 hours after death with the Maryland ene. than "neturel" or Items 23e or 28s-f show the Madigal Examine ritest by rediffied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 DANo If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar I ☐ Yes 2 X No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		Race - Amend Black, White, ecify: B		
Maryland 21215-0036	of 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 27 is marked other than "neturel", or Iteme 23e or 28a-f show treumatic event, the Medical Examinar mast be confilled at	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	(cation 16a College (1,4gr 5+)	. Deced (Give life, L	lent's Usual Occupa kind of work done di DO NOT use retired)	uring most of v	vorking	16b. Kind	of Business/In	dustry an c r	^
ryland	should be filed ind Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) JOHN SIMMS 19a. Informant's Name/Relationship (7)	(ga Print)	Mailin		Ali	lame (First, Middle,		mame)		
_	Heal Heal tem 2		Glona Sligh/Gr 20a. Method of Disposition	and Daughter 3	of Dispo	g Address (Street and Property of Street and	y Stre		imor	e MD ion - City or To	2121	0
Baltimore ,	permit. Pages Department of I Important: If Its any njury or o once.		1 D Surial 2 Cremation 3 F '4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Nemoval from State	+. 2	Zion Name and Address Allghn Cit ISVBalt	02	·28.05	Balienic	timore es Bai	e MD	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a consequence	not ente	er the mode of dying	, such as card	iac or respiratory and	rest,		Approximate Interval Betwonset and C	e ween
8760,	cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence				1)02			P	
.O. Box 6	the death certifi y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23d.	Date of delive	-	'ear
ords, P	The law requires that ite has been signed b page 2 should be deta	leted by P	Part II. Other significant conditions co	ntributing to death but not resulting i	in the ur	nderlying cause given	n in Part I.		obacco use d	contribute to the	~	eath? Inknown
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of	ath. ath. rr: After this re funeral di	ation; To B	examiner?		utpatien Time of Injury	t 3 DOA Other	. 4 Nursing	Peath (Check only of Home 5 ☐ Residence 1 28d. Describe h	lence 6 🗆		y)	
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	To the Hospitel or Atte within 24 hours efter de To the Funerel Directo completely filled in by th	Medical	29b. Signature and title of certifier	sician: To the best of my knowledgener: On the basis of examination are and manner stated.)	estigation, in my opi	nion, death oc	curred at the time,	date and pla	ce, and due to	the cause(s)	
)	6		30. Name and address of person who co	ompleted cause of death (Item 23a)	(Туре,	Print)	1844		7/2	3/5	21	212
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 0 4 2005	ompleted cause of death (Item 23a)	los	nmarch	Ferr	y Ref 1	SAG	m,	2	

ANNIE M. WILLIAMS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 19a per fh 9841 3-4-05 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 8:58 A^{M} Sonald 26, FEBRUARY /Medical 2005 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical (4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 4-24-5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours Min 213-46-475 Yrs. Director 19110 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show an item must be notified at 1₽Yes 2□No Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 60 Gale 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian The Medical Examiner Black, White, etc. filed within 72 hours after Yes 2 No 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Yes. Give Be Completed by 3 ☐ Widowed 4 ☑ Divorced Black Year or Dates: natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Shipping Supervisor Business marked other nt of Health and Mental Hygi : If Item 27 Is marked other or other traumatic event, I 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be f nent of Health and Mental I ant: If Item 27 Is marked o arton Warren Wilson 2 Mrs. Priscilla Winchester-Wilson Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) Gate 15C1/18 501604 N 111.21229 na 4.more 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/8 Department of Important: If any injury or once. 2005 Green Mount Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Ficility Home 1to. md. 21216 23a. Pand Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faithre. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYDCARDIAL INFARCTION W. North Ave. Approximate Interval Between Onset and Death Pnysician /Medical Due to (or as a consequence of): Examiner SEVERE CORONARY ARTERY DISEASE Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 🗌 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, BRADYCARDIA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1 Yes 2 X No Division of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 📉 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred After 1 X Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours a To the Funeral L filled 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) npletely and manner stated 29d. Date signed (Morth, Day, Year) 29c. License number 29b. Signature an 6 D 24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I OW, M. TIMOTHY: 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32.1

2005

		1 - For Stata Registrar	State of I	Marylan	d / Depa		t of H	ealth and	Mental Hy	•	05	07264
Physici	an	Decedent's Name (First, Midd	dle, Last)						2. Date of De Month	aath Day	Year	3. Time of Death
/Medic		Catherine		lker_					March		005	9:40P ^M
Examin	er	4a. Facility Name (If not institution		er)				Location of Dea	th		ty of Death	
		5409 Hutton Av 5. Social Security Number		Ane (In vrs	last birthday)	If Under	dlawı	If Under 24 Hrs	8. Date of Bir		1timor	
Funeral Director		215–28–8735 Usual Residence of Decedent	1 M 2 Z F	76	Yrs.	Months		Hours Min		ay, Year)		place (State or Foreign ntry) Land
ylanc how		10a. State 10b. Count	у	10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
e Ma	cto	MD Balt	imore		V	lood1a	awn					1 Yes 2 No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene important: if Item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other treumetic event, the Wedical Examination militarial angles.	Funeral Director	10e. Street and Number				10f. Zip	Code			10g. Citizen o	What Cour	ntry?
ath w	rai	5409 Hutton						21207		U.S		
er de Item	nue	 Marital Status Never Married 2 Ma 	12. Was Decede Armed Force	s?	S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No to Rican, etc.)	>- 14. Ra	ace - Americ ack, White,	
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Aar 2 sho 2 sho 1 s md		19a. Informant's Name/Relation							u <i>ral R</i> oute Numb			Code)
Ce, N 1 and 1 Health Health Jem 27		Rita Saltysi	ak - Cousin	20h B	3649				timore,	MD 2124	4	
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Itin It. Pa It. Pa Itent Itent Ilury		' 4 □ Donation 5 □ Other (Lo	rraine	Park	Cem	. 3/7	/2005	Woodle	wn, M	D
Balt permit. Departimport any init		21. Signature of Funeral Service			7	. Name an	a Addres	s of Facility Wi	tzke Funer	ral Home	of Cato	onsville,Inc.
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aw requir s been si s should	ojet		,	, ,					24a. Was	an 24b	Were autor	osy findings available
The tav The tav ate has page 2	Completed									rmed?	prior to con death?	npletion of cause of
	a	25. Was case referred to medica	al					26 Place of De	1 ☐ Yes ath (Check only o	2 No	1 Yes	2110
	OB	examiner? 1 ☐ Yes 2 ☐ 10	Hospital: 1 ☐ Inpa	itient 2 1	ER/Outpatien	t 3 DO	A Othe	r: 4 🗆 Nursing F		dence 6 Ot	her (Specify	·)
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	atio	2 - 1100100111	igation	July 1 Gary	injury	М		es 2 □No				
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To the Hospitel within 24 hours a To the Funerel Completely filled in	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred a restigation,	at the time in my op	e, date and place inion, death occu	a, and due to the urred at the time,	cause(s) and m date and place	anner as sta , and due to	ated. the cause(s)
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4.		Char le	AND LOOP				D3	0631		3/3	105	
6		30. Name and address of person	who completed cause o	death (Item		Print)	Geis	e Ro.	Bolt	DE	5 2	1228
Sta Registr		31. Date filed (Month, Day, Year MAR 0 4 20	32. Regi	strar's Signat	ture Space	r)		1				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 27, 2005 6:00 P.M Marjorie N. Woods February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2 F 92 Director Dec.20, 219-30-9085 1912 Michigan Usuat Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death y 47_Glenwood_Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status Black. White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien important: if Item 27 is marked other the any injury or other traumatic. 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Victor S. Nystrom Edna Gee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 Glenwood Avenue; Baltimore, Maryland 21228 Mary Jo Woods Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mt. View Cemetery 3/4/05 Ellicott City, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc.
736 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ONGESI /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) Records: P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 peq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dinknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed Division of Vital 1 ☐ Yes 2 No To the Hospital or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 0 MAR Registrar

			For State Registrar	State of M	Maryla	-		nt of H <i>te of L</i>		nd Me	-	jiene leg. No.	005	07266
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	Examin	er	4a. Facility Name (If not institution, give s				4b. Cit	/, Town, or	Location of D			4c.	County of Death	
	Funeval		5. Social Security Number 6. Sex	urg Luthera		(e Last birthday)	If Und	er 1 Year	If Under 24	Baltimo	Date of Birth			imore
H	Funeral Director			M 2√F		Yrs.	Months	Days	Hours I	Min.	(Month, Day Sep 21	, Year)		pplace (State or Foreign intry) Virginia
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	show	<u>_</u>	10a. State 10b. County		10c. C	lity, Town or Lo	cation							10d. Inside City Limits
	8e-f	Director	Maryland N//	<u> </u>					altimore					1 X Yes 2 □ No
	with t	DIE	10e. Street and Number				10f. Z	ip Code	04045		1	0g. Citiz	zen of What Cou	
	ns 23	Funeral	5713 Rubin Ave	2. Was Deceder	nt Ever in	II S 13 V	Was Dec	adent of His	21215		fy Vas or No-	1 1	U.S.	
•	r Itan	Fun	1 ☐ Never Married 2 ☐ Married	Armed Force	s?	10.0	f Yes, sp	ecify Cuba	n, Mexican, P	uerto Ri	fy Yes or No- can, etc.)	[]	Black, White	
21215-0036	ral', o		3 Widowed 4 □ Divorced	If Yes, Give Year or Date:	• •		1 🗌 Yes	2 XN0	Specify:				Specify:	Black
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N	lled v lygie ther t nt, th	Co	17. Father's Name (First, Middle, Last)			<u> </u>		Hom	emaker	Nama /	First, Middle, i	t do into o	C	
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	nd 2 lith ar 27 is r trau		Howard Washington								Maryland			<i>p</i> 0000,
altimore,	s 1 and 2 of Health itam 27 I		20a. Method of Disposition			Place of Dispo	sition (N	ume of		Dat			cation - City or T	own, State
Ë	Page nent o nt: If iry or		1 ☐XBurial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	te			Cemet	I	03	3/03/05		Baltimore,	Marvland
ᆲ	permit. Pages Department of h Important: If its any injury or of		21. Signature of Funeral Service License	e / /-			. Name a	nd Addres	s of Facility					
n —	8258	1 17	· Cell 4	40 Ce	#	4	Ē	step B	rothers Fu	uneral	Home P.	A.	17	
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caus e cause on each	d the dea	th. Do not ente	er the mo	de of dying	, such as car	rdiac or r	espiratory arr	est,	**	Approximate Interval Between
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7	law requires that the as been signed by th 2 should be detache	Ph	Part II. Other significant conditions con	tributing to death	but not re	sulting in the ur	nderlying	causa dive	n in Part I		23e. Did tol	pacco us	se contribute to I	the cause of death?
Kecords,	uires tha signed I id be det	d by	ATRIAL FIBRILL				,,	3				s 2[_
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0	uttandir death. ctor: Af y the ful	atlo	1 Natural 5 Pending investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,		М		es 2 No					
DIVISION OF	of or Attand after death Diractor: A	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building,	Injury - At i	nome, farm, stre	et, facto	ry, office		28f	Location (St. City or Town	reet and n, State)	Number or Run	al Route Number,
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	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the bea er: On the basis and manner	of examin	owledge, death ation and/or inv	occurre estigatio	at the time n, in my op	e, date and pi inion, death c	lace, and occurred	d due to the ca at the time, da	ause(s) a ate and p	and manner as s place, and due t	stated. o the cause(s)
	To tha Hos within 24 h To tha Fur completely	Med	29b. Signature and title of certifier	and manner	Stateu.		29	c. License	number		2	9d. Date	signed (Month,	Dav. Year)
	⊢≯⊢ŏ		Villaga OK	2					H 459	31			ray 25	
	Ň		30. Name and address of person who co	apleted cause of	f death (Ite	m 23a) (Type I	Print)		11-100	J.	11.0	IN U	icey ocs	مال
	N		Dr. Deborah Pie			ark He	igh	ts A	venue.	-Ba	ltimoz	re	Marvls	and 21208
	Sta		31. Date filed (Month, Day, Year)	32. 39 gis	strar's Sign	atura	parte	1				,	······································	
	Registr	ar	MAR 0 4 20		24	~ /9								

Horin Washington

			1 - For State Registrar	State of Mary		artment of F			iene 0 0 5	07267
			1. Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
	Physici /Medic		Marjorie Ward					March 02	2. 2005	6:00 PM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of De		4c. County of Deat	
			Heritage Harbour	Health Cent	er	Annapoli	S		Anne Arur	nde1
	Funeral		Social Security Number 6. Se	x 7. Age (In ☐ M 2 ☐XF	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Birth	Year) 9. Birt	hplace (State or Foreign untry)
	Director		370-34-3127		91 Yrs.			n. 07/14/19	Penr	nsylvania
	and		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation	·			10d. Inside City Limits
	Marylan f show	ō	Maryland Anne Aru							1 X Yes 2 No
	286 286	Director	10e. Street and Number	nder /	Annapoli	10f. Zip Code		11	Og. Citizen of What Co	unto/2
	3a or	٥	2700 South Haven	Poad		21401				unity:
	death	Funerai	11. Marital Status	12. Was Decedent Ever		Was Decedent of H	ispanic Origin?	(Specify Yes or No-	JSA 14. Race - Ame	ncan Indian.
ယ္	after or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐XNo		If Yes, specify Cuba	ın, Mexican, Pu	erto Rican, etc.)	Black, White	e, etc.
93	rel', o	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify: Whi	te
5-0	be filed within 72 hours after death with the Maryland Hylyiene. ad other then "naturel", or items 23a or 28e-f show other then "naturel", or items 23a or 28e-f show event, the Modical Examination in the notified at	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece	dent's Usual Occup	ation	vodkina	16b. Kind of Business/	Industry
21	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	, or all years		
2	filed v Hygiel Sthertl		12		Nı	urse			Medicine	
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, the Ma	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, M	Maiden Sumame)	
<u>₹</u>	should be fand Mental Band Mental Band Mental Bandwarked ol	P	Unknown 19a. Informant's Name/Relationship (Ty	and Defeat	401 14 25			Johnson		
Ma	d 2 si		Ronald Ward/ Son	pe, mini)					City or Town, State, Z	(ip Code)
	ss 1 and 2 should of Health and Mer item 27 Is marke rother treumatic		20a. Method of Disposition	20	Ob. Place of Dispo	Riva Roa	a Anna	polis, MD	ZI4UI 20c. Location - City or 1	Town State
Baltimore,	0 0		1 🔀 Burial 2 □ Cremation 3 □ F		cemetery, crer Lake Memorial	matory or other plac	· 1			
Iţ.			 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Ligens 		Memorial	Gardens	03/	07/2005 I	Oavidsonvil Evans Funer	le, MD
Ba	permit. Departr Importe any inju		1111	5					, MD 20715	
			23a. Part1. Enter the disease, or compl	lications that caused the						Approximate
	Obvesialan		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	/	1	3 ,	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. ASALVO	en Fr	William				yell
	Examiner			24910 (01 43 4 00)	isoquonos oi;					
		Jer	if any leading to immediate	b. Due to (or as a cur	isequence of):					
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
o,	e exe	EX	resulting in death) Last	Due to (or as a cor	rsequence of):					
8760,	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai		d						
9	ertific ling p e as	Mec	IF FEMALE:		-					
Вох	eath certiffic attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy			23d. Date of deli	very Day Year
o.	it the de by the a tached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	or death 5L	Other (specify)				
۵.	that ted by		Part II. Other significant conditions cor	ntributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	uires I sign Id be	d by	Dementre			, ,		1 □ Ye.		
00	w require been sig	Completed						24a. Was ar	24h Wara aut	langu findings available
Re	The far ate has page 2	mc						autopsy	prior to c ned? death?	opsy findings available ompletion of cause of
		e Cc	25. Was case referred to medical				Pi (P	1 ☐ Yes 2	No 1 ☐ Yes	2 X No
Ś	Physicien: this certificatal director,	o B	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	nt 3 DOA Othe		eath Check onl one	nce 6 Other (Spec	R.1
		\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Yea		28c. Injury	at	28d. Describe ho		ny)
ion	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	nr) Injury	Work M 1 □ Y	<br Yes 2 □ No			
Division	of or Attendation of after death Director:	ific	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory, office			eet and Number or Ru	ral Route Number,
Ö	safter safter el Direc	Certification:	4 - Homeise	building, etc. (3)	Jecny)			City or Town,	, State)	
	in on the	edicai	29a. Certifier 1 Certifying Physics (Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exa	knowledge, death	occurred at the tim	e, date and place	ce, and due to the ca	use(s) and manner as	stated.
	등 로구 등		(and any 2 modical cadim	and manner stated.	mination and/or in	vestigation, in my of	Jinion, death oct	curred at the time, da	te and place, and due	to the cause(s)
	the Hospitel or nin 24 hours afte the Funerel Dire npletely filled in b	ledi	one)							
	To the Hospitel or within 24 hours afte To the Funerel Dirt completely filled in h	Medi	29b. Signature and title of gentiler			29c. License		29	d. Date signed (Month	, Day, Year)
)	To the Hos within 24 h To the Fur completely	Medi	29b. Signature and title of pertitler	MD		D389		29	3/3/05	, Day, Year)
)	To the Hos within 24 h	Medi	one)		(Item 23a) (Type,	D 389	155		3/3/05	
	To the Hos within 24 h To the Fur completely	W	29b. Signature and title of pertitler		413 An	D389	155		od Date signed (Month)	

DHMH 17 Rev 1/2001

		4	State of Maryland / Department	artment of Health and Me	, ,	2005	07260
			Registrar 1. Decedent's Name (First, Middle, Last)		Re 2. Date of Death	g. N6 U U J	3. Time of Death
и	Physicia		Robert D. Williams		Month ebruary	Day Year	
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ebruary .	4c. County of Death	2:00 A. M
	Examin	er	3148 Gracefield Road	Silver Spring		Prince Geo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. g	B. Date of Birth	9 Birth	place (State or Foreign
М	Director		117-09-4284 1 [™] 2□ F 85 Yrs.	Months Days Hours Min.	(Month, Day, pril 23,	1919 New	York
	p _		Usual Residence of Decedent				
	arylar show	_	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits
	8a-f	Sch	Maryland Prince George's Silver S				1 ☐ Yes 2 No
	with th	급	10e. Street and Number 3148 Gracefield Road	10f. Zip Code 20904		og. Citizen of What Co	
	s 23	rai				United Stat	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked othar then "natural", or Itams 23a or 28a-f show othar traumatic event, the Macilian Examinal must be notified at	by Funeral Director	Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 ☒ No Specify:	ican, etc.)	Black, White	, etc.
21215-0036	hour			dent's Usual Occupation	1	16b. Kind of Business/I	nduetna
5	in 72 "na hedic	Completed	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	'	TOD. KING OF BUSINESSY	ilidustry
72	iene.	luo	Elementary/Secondary (0-12) College (1-4or 5+) 4 Certif	ied Public Accountant		Accounting	5
ğ	e filed within al Hygiene. othar then " vant, the Me	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	faiden Sumame)	
<u>a</u>	Mental Mental arkad o	To E	Ernest Williams	Laura Jac	obson		
ary	2 should be and Mental Is markad raumatic ev		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural	Route Number,	City or Town, State, Z	ip Code)
Σ	ss 1 and 2 of Health Itam 27 I		Louise S. Williams/ Wife 3148	Gracefield Road, S	ilver S	Spring, MD.	20904
ore	of He		20a. Method of Disposition 1 Burial 2 M Cremation 3 Removal from State 20b. Place of Disposition Cemetery, cree Mont companies	matory or other place) March	^{te} 2.	20c. Location - City or 1	Town, State
Ë	Pag ment ant: I ury o		`4 □Donation 5 □Other (Specify) Cremato	rium, Inc. 2005	E	Bethesda, M	
Baltimore, Maryland	permit. Pages 'Department of H Important: If Its any injury or ot		21. Signature of Funeral Service Licensee M01353	2. Name and Address of Facility Robe ethesda-Chevy Chase ethesda, Maryland 2	rt_A. P 1nc 20814-35	Pumphrey Fu 7557 Wisco 501	neral Home/ nsin Avenue
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	- Pnysician	S (9	Immediate Cause (Final disease or condition Parkinson's Disea	S.P.			Onset and Death Years
	/Medical		resulting in death) a Due to (or as a consequence of):				Tours
	Examiner	.	Sequentially list conditions. b.				
,-	ad sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of Light y			Į	
	be executed ician and burial-transit	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	be executed sician and burial-transit	a E					
687	icate physics the b	edicai	d				
Box (death certificate le attending phys ad for use as the	/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
Ä.	death (e atten d for u	Physician/M	in the past 12 months? 1 Yes 2 No. 4 Pregnant at time of death 5[□Ectopic pregnancy □ Other (<i>specify</i>)		Month	Day Year
0	the ache	hys	9 ☐ Unknown				
s, P	de de	by P	Part II. Other significant conditions contributing to death but not resulting in the to Dysphagia, Recurrent Pneumonia,	underlying cause given in Part I.		acco use contribute to	
ord	w requir been si should	ted			1 ☐ Ye	s 2ÃNo 3∏Pro	bably 4 Unknown
Vital Records,	m 901	Completed	Degenerative Joint Disease		24a. Was ar autopsy	v prior to c	opsy findings available ompletion of cause of
=		S			perform 1 Tes 2		2 🗌 No
/ita	iclen: T certificet rector, pa	Be	25. Was case referred to medical examiner? Hospital: A Description of TEDIO 1997	26. Place of Death /			
of	Phys this al dir	2	1 ☐ Yes 2 🛣 No ☐ Spiral: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death			nce 6 Other (Spec w injury occurred	ity)
	ing After une	tion	1 XNatural 5 ☐ Pending (Month, Day Year) Injury	of 28c. Injury at 28 Work? M 1 ☐ Yes 2 ☐ No	od. Describe no	w injury occurred	
Division	l or Attanding after death. Director: After	fica	3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury - At home, farm, st		3f. Location (Str	reet and Number or Ru	ral Route Number,
Div	i i i i i	Certification;	4 Homicide determined building, etc. (Specify)		City or Town	, State)	
	To the Hospital or within 24 hours afte To tha Funarel Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, an ovestigation, in my opinion, death occurred	nd due to the ca	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
_	ro th within ro th compl	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	Day, Year)
	. > - 0		> Yelle	D24035	Fe	ebruary 28	, 2005
	5		30. Name and a re s of person who completed cause of death (Item 23a) (Type Eugenio Machado, M.D., 3110 Gracefie		ing. Ma	irvland 209	04
	Sta Regista		31. Date filed (Month, Day, Year) MAR 0 4 2005 32. Registrar's Signature			J = 200	
		»l	· · · · · · · · · · · · · · · · · · ·	Cinasis II			

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Year **Physician** Jilliams trances Fribrusty M9 5221 2005 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner itheran om e If Under 24 Hrs. & Date of Birth Security Number 7. Age (lg yrs. 8. Date of Birth (Month, Day 6. Sex last birthday) 9. Bitthplace (State or Foreign **Funeral** Months Days Hours 214-40-567 Usuel Residence of Decedent 1 □ M 202 F Director with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ahov traumatic event, the Medical Examiner nust be notified at 1 XYes 2 □ No Funeral Director mor 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Ave. 206 ring Peges 1 and 2 should be filed within 72 hours efter death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Maritel Status 14 Race -American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Be Completed by 3 Widowed 4 □ Divorced naturai Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry n end Mentel Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informent's Name/Relationship (Type, Print) (Son) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health a important: if item 27 is any injury or other trau etown Nd. 21769 20c. Location - Oty or Town, State LGrayson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 'alle 27 Name and Address Facility
Joseph L. LUS
2222 W. NOTH 21. Signature of Funeral Service Licenses ray tom W. North Enter the disease, or complications or heart failule. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires thet the death certificete be executed Sequentially list conditions, it any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yee 2 3No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? certificate has 1 Tes 25 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 → Nursing Home 5 □ Residence 6 □ Other (Specify) 10 Hospital: 1 Yes 2₺No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after deeth.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death . Date of Injury (Month, Dey Year) 28c. Injury at Work? edical Certification: 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certitier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) March 2,2005 30. Name end eddress of person who completed clause of death (Item 23e) (Type, Print) 25 Main 719-015 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar MAR 0 4 2005

		-	For State Registrar	State of Maryla		artment of H			iene 05	07270
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month		3. Time of Death
	Physicia /Medic		Dorothy	Spangler	Acost	a		February	40 000	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	ath	4c. County of	Death
			Shady Grove Adven	tist Hospital		Rockvi				gomery
	Funeral		5. Social Security Number 6. Se	7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days	If Under 24 Ha	n. (Month, Day,	Year) 9	Birthplace (State or Foreign Country)
	Director		214-42-2165	6.	3 Yrs.			Jan. 14,	1942	PA.
	and *	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits
	/anyl	ō	Manusland Mantagne		Mantaam	ery Villa	~^			1 ☐ Yes 2X No
	28a-	Directo	Maryland Montgome 10e. Street and Number	EL y	Honegom	10f. Zip Code	ge	1	0g. Citizen of Wh	at Country?
	with ta or		19505 Gallatin Co	urt		20886			United	States
	leath	era	11, Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No-	14. Race -	American Indian,
٥	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Exacid at most be notified at	Funerai	1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cuba	n, Mexican, Pue Specify:	erto Rican, etc.)		White, etc.
215-0036	ral', c	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		112 195 2 <u>2</u> 1NO	Specily.		Specify:	White
ر د	72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occupa	durina most of w		16b. Kind of Busin	ness/Industry
	han a	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)		II	_
2	led w fygie her ti	S	17. Father's Name (First, Middle, Last)	2	H	ousewife	18 Mother's N	ame (First, Middle, I	Home	
מש	0-05	Be		77	4		TO. INIOLIDI 3 IV			
Maryland 21	12 should be filed w n and Mental Hygier Is marked other tr raumatic event, in	٦ و	Lawrence 19a. Informant's Name/Relationship			no Address (Street	and Number or i	Evelyn Rural Route Number		Sweigert
Ma	d 2 sl th an 7 Is r traur		Ernest Acosta/Hus							
o,	1 and Health em 27		20a. Method of Disposition		. Place of Disp	osition (Name of			20c. Location - Ci	ty or Town, State
ية	Pages nent of Int: If It		1 Burial 2 □ Cremation 3 □			matory or other place		19/2005	'h a san a h	wa Marviland
altimore,	it. Partment		*4 □Donation 5 □ Other (Specification of Funeral Service Licer			View Cem 2. Name and Addres	4 - 10			rg, Maryland
Ba	permit, Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		Michael	CA July	V		1	DeVol Fune		e g, MD. 20877
	_		23a. Part1. Enter the disease, or com	plications that caused the de						Approximate
i.			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		1	_			Interval Between Onset and Death
	Physician / Medical		disease or condition resulting in death)	a. Metastet Due to (or as a cons		reust	Canc	٧.		2 years
ı	Examiner			Due to (or as a cons	equence on.					
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):					
	uted d ansit	m	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć	exec an an rial-tr	Examiner	resulting in death) Last	Due to (or as a cons	equence of):					
8760,	cate be executed physician and the burial-transit	Physician/Medicai		d						
õ	rtifica ng ph as th	Jed	IF FEMALE:							
Box	eath certific attending p I for use as	an/J	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1☐Live birth 2☐Fe		□Ectopic pregnancy			23d. Date Month	*
o.	e dea he at ned fo	sici	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	f death 5	Other (specify)				,
<u>م</u>	that the de ned by the a detached f	Phy	Part II. Other significant conditions of	contributing to death but not	reculting in the	Inderhing cause div	en in Part I	23e Did to	bacco use contrib	oute to the cause of death?
	8 5 9	by	Part II. Other signmount conditions	Office State of the Control of the C	osularig ar tho	andonying dadoo giv	on an area.			Probably 4 Unknown
Vital Records,	w require been si should	Completed						040 1450	245 346	are extensy findings available
3ec	The law cate has I page 2 s	du						24a. Was a autops perfor	sy pri med? de:	ere autopsy findings available or to completion of cause of ath?
a								1 ☐ Yes	2 1 1]Yes 2□ No
<u> </u>	Physician: this certifican al director,	Be	25. Was case referred to medical examiner?	Hospital:	T 50/0	oth Oth	er	eath (Check only or		(01)
ō		- To	1 Yes 2 Ho	28a. Date of Injury	☐ ER/Outpatie	XIII 3 DOA	4 140131119	Home 5 Reside	ow injury occurred	
uo	ding Phy. h. After thi funeral	tion	1 ☐Natural 5 ☐ Pending	(Month, Day Year		Wor	k? Yes 2 □No	- Address		
Division	or Attending after death. Director: After in by the fune	ertification:	3 Suicide 6 Could not b	e 28e. Place of Injury - A	t home, farm, s	treet, factory, office				or Rural Route Number,
$\frac{1}{2}$	after after Dire	erti	4 Homicide	building, etc. (Spe	ecity)			City or Tow	n, State)	
	Hospital 24 hours a Funeral I	aic		nysician: To the best of my						
	To the Hospital or Attendwithin 24 hours after death To the Funeral Director:	ledicai	(Check only 2 Medical Example one)	miner: On the basis of exam and manner stated.	ination and/or i	nvestigation, in my o	pinion, death of			
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	Ť		30. Name and address of person who						,	
			S. Michael Gharac	holou, M.D.,	9901 M	edical Ce	nter Dr	., Rockvil	lle, MD.	20850
	St Regist	atė rar	FEB 1 7 2	32 legistrar's Signatur	J. A	me				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CATHERINE N 2:00 PM 2005 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner hospital Gi Southern CLINTON Marylana COUNTY 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 2, 19 5. Social Security Number Birthplace (Stete or Foreign Country) **Funeral** 1□M 20€F Days 86 Feb. Director 577-01-6295 Washington DC 1919 Usuet Residence of Decedent death with the Maryland Health and Mental Hygiene. It has the 23e or 28e-1 show other traumatic event, the Madical Examine. must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes & No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 774 University Drive 20602 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Godfrey Darmstead Mary Bertha Rackey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Pontorno - Daughter 774 University Drive, Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete permit. Page Department of Important: If any injury or once. Cedar Hill Cemetery 2-21-05 Suitland, Maryland 21. Signature of Funeral Service Licensee P. O. Box 156, Waldorf, MD 20604 M01391 of of text Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SeD **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the buriat-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death
9□ Unknown Month Day Year signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page autopsy 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient Director: After this of in by the funeral dir 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tittle of certifier D0062394 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURRATTS ROAD #307, CLINTON, MD aup MD 750 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State FEB 1 7 2005 Registrar

DHMH 17 Rev 1/2001

Arthur, Radie

			1 - For State Registrar	State of M	aryland		artment o rtificate o		ınd Mental H	ygiene Reg. No. 0)5	07272
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ı	Funeral Director		214-07-2621		ge (In yrs. Ia 96 	ast birthday) Yrs.	If Under 1 Ye Months Da		Min. 8. Date of E (Month, I) July	Birth Day, Year) 31 1908	9. Birth Cor West	nplace (State or Foreign untry) Virginia
	death with the Maryland me 23a or 28a-f ehow frivet be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County Allegal	ny	10c. City	Weste	rnport					10d. Inside City Limits 1 ☐ Yes 2X No
	h with the 23a or 28 51 be no	al Director	10e. Street and Number 21014 Lower Georg	rges Creek	Road		10f. Zip Cod 21	562		10g. Citizen of United		
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or fleme 23a or 28a-f show any injury or other treumatic event, the Medical Examination in at the notified at ance.	by Funeral	11. Marital Status 1汉 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yes 20 If Yes, Give Year or Dates:			Was Decedent of Yes, specify C		in? (Specify Yes or N , Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: White		
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altimore,	Pages 1 and nent of Hesen ant: If item ury or other		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec		Ce	emetery, crer	sition (Name of matory or other) emetery	place)	02/25/ 2005	20c. Location Western	-	Town, State Maryland
Dall	permit. Departr Importa any inju		21. Signature of Funeral Service Lic	ensee Bal	/	1	Name and Ad	dress of Facility	Boal Fune Westernpo	eral Home	e yland	l 21562
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vitai necorus,	n: The law ra ficate has be rr, page 2 sh	e Completed		lar D	y's fe	meti	in		per 1 ☐ Yes	opsy formed? 2/2 No	Were autoprior to codeath?	opsy findings available ompletion of cause of 2 No
DIVISION OF VII	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigati			ER/Outpatien 28b. Time of Injury	28c. II	Other M	lo	sidence 6 Ot how injury occu	rred	
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	Sta Registr		30. Name and address of person who Jesus Tan, 31. Date filed (Month, Day, Year) FEB 2	MD 10	death (Item	23a) (Type, New ure	Clorge Loval	s Cree	K Rd, S.1	w. Frost	burg	23, 2005 1, MD 2153

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** February 17, 2005 2:25P M Carole McNally Barry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ocean Pines Worcester 51 Watertown Rd. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours Months Washington, D.C. 1 □ M 2 🕱 F July 26,1944 Director 217-44-3862 60 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b County rthen "neturel", or items 23a or 28e-1 show the Medical Examiner oust be notified at 1 ☐ Yes 2 No Ocean Pines Funeral Director Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number US 21811 51 Watertown Rd. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Affied Forces? 1 ☐ Yes 2 **②X**No If Yes, Give Year or Dates: 1 Never Married 2X Married Specify: White Maryland 21215-0036 1 ☐ Yes 💥 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Human Resources Manager Tel emarketing Pages 1 and 2 should be filed v itment of Health and Mental Hygie rtent: If item 27 le marked other t jury or other treumatic event, ID. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eloise Hite George McNally 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John Barry (Husband) 51 Watertown Rd., Ocean Pines, Md. 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Importent: If eny injury or once. Cape Henlopen Crematory 2/21/05 Frankford, DE 1 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home fre of Funeral Service Licensee 108 William St., Berlin, Md. 21811 MOONS art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Mutactatic Fnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, bading to an account cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consa uence of]: Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) physician a s the burial-P.O. Box 68760 Physician/Medicai IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🔀 No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 2 00 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 X No 1 ☐ Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 X No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) Signature and title of certifier N26278 30. Name and address of person who completed cause of death (Item 23a) (Type Print) P.O. 31. Date filed (Month, D EB 1 8 2005 egistrar's Signature State Registrar

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St Regist	ate trar	31. Date filed (Month, Day, Year)		gistrar's Signa		and of									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 14 February **Physician** Kenneth C. 2005 Bailey 6:55 Ам /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 9327 Jarrett Court Montgomery Village Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y May 12, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ★M 2 ☐ F 219-48-7767 56 WV Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show the Medical Examinant hast be notified at 1 ☐ Yes 2X No Director MD Montgomery Village Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9327 Jarrett Court 20886 naturel', or Items 23a United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. of filed within 72 hours after de til Hygiene. other then "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 🕅 Divorced 1976 White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Importent: If item 27 is marked other the any injury or other traumatic event, the once. Installer Cable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert W. Bailey Sr. Margaret P. Cleveland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9327 Jarrett Court, Montgomery Village, MD 20886 Kennetha M. Walker / Daughter 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State February 22 MD Veterans Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 East 1 RACI Deer Park Drive, Gaithersburg, MD 20877 TUU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANTERIOSCLENOTIC CALGOUNSCULTAL DISEASE Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 X No certificate has 1 Yes I or Attending Physiclan: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 28a. Date of Injury (Month, Day Year) pletely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Injury 5 Pending 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No М Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital o within 24 hours af To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as occurred.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check o 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 015236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE POCKVILLE PLAT, BOCKULUE, MO ang. I margeur 31. Date filod (Month, Day, Year) 32. pgistrar's Signature State 1 7 2005 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Wilbert Clinton Bittinger 20, 2005 11:50 am February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Grantsville Goodwill Mennonite Home If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 112 M 2□ F 218-16-4182 Aug 29, 1925 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural; or items 23a or 28a-f ahow ary or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Grantsville MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21536 16010 Bittinger Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: 2 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fire Brick Manufacture Laborer 5 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Celia Wilt Lloyd Bittinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4295 Maynardier Ridge Rd., Grantsville, MD 21536 Jeanne Meyers/stepdaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Feb 26, 2005 Grantsville, MD Grantsville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Newman Funeral Homes, P.A., PO Box 275 lemac 179 Miller St., Grantsville, MD 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician CONGESTIVE NEART FAILURE Immediate Cause (Final disease or condition resulting in death) /Medical 420RS Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? CHRONIC OBSTRUCTIVE Dulmonsky 1 Pres 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MALLITUS 24a. Was en autopsy performed? Completed RENAL FAILURF CHRONIC 1 🗆 Yes 2 10 No 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Mannet of Death 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fr 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 256 38

cause of death (Item 23a) (Type, Print)
10701 New Heary, Creek S.W Frostburg Matry LAND 215-32

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

STUDNING CHANG.
31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pay 15, 2005 **Physician** 4:15 P M Thomas Elmer Brooks /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year | 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral X**□M 2□F Yrs. Director 216-40-7093 62 September 6,1942 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "netural", or Items 23s or 28a-f show any injury or other treumatic event, the Musical Event. 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits XXYes 2 No Maryland Prince Georges Clinton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 8600 Mike Shapiro Drive Apt. 618 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Black Specify 3X Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Industry Truck Driver 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Everlena Gray Thomas Abraham Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3414 Navy Day Drive Suitland, Maryland 20746 Christine King / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Phillips Ch Cem 2/21/05 Aquasco, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home P.A. Aquasco, Maryland) de soa MO1323 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intracerebral Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the ar 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hemo itralige is Depresident End Stage Renal Discore 1 Yes 2 No 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2 No 1 Yes 2₩No : After this certifica e funeral director, r Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title 29d, Date signed (Month, Day, Year) (my) 00055120 tes m Arry 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WashinghonDC Richard Palmer MD 1328 Southern Avenue SE Soute 310 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Marie 2005 Registrar

		1	For State Registrar	State of Marylan		artment of H		fental Hygier		07278
	Physicia	ın	1. Decedent's Name (First, Middle, Last) Elsie		Boon	e		2. Date of Death February	Day 15, 20(3. Time of Death 05 10:15 AM
) Opposite	/Medic Examin	al er	4a. Facility Name (If not institution, give s Prince George's	treet and number) Hospital		Chev	-	F		George's
1	Funeral Director		212 24 2020	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Mar. 26, 1	921 Mar	hplace (State or Foreign untry) Cyland
	Aaryland ahow ed et		Usual Residence of Decedent 10a. State 10b. County D . C .		y, Town or Lo Washi					10d. Inside City Limits 1X☐ Yes 2☐ No
	with the Name or 28a-	i Director	10e. Street and Number 2904 Nelson Pi	lace SE		10f. Zip Code 200	19	10g.	Citizen of What Co USA	ountry?
736	filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene than "natural", or Itams 23a or 28a-f ahow nither than "natural" or Itams 11a Maryland Examiner must be notified a	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 █ No	lispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify: B1 a	e, etc.
9500-61212	within 72 hou iene. than "natura the Madical E	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired mestic	pation during most of word d)	king	.Kind of Business/ Someone Lome	
Maryland	b d la b	To Be C	17. Father's Name (First, Middle, Last) William	S	mith		Sarah	ne (First, Middle, Maid	Dare	
	is 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty Darlene Simms/)	Daughter	1318	Samuel	Drive		Heights	s,MD 20743
Baltimore,	mit. Pages 1 a partment of He portant: If iten injury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 F 1 Donation 5 Other (Specify)	Pa	tuxen	sition (Name of matory or other plant t UMC C	em. 2/2	1/05 Hu	Location - City or	own, MD
Ball	Departi Departi Import any in		21. Signature of Funeral Service Licens Blady A. 23a. Part1. Enter the disease, or comp	Sewell					nce Fre	ome ed.,MD20678
,1200	Physician /Medical Examiner the private fransit	l Examiner	shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SEVERE Due to (or as a consequence)	SION quence of): SION quence of):			VOPATHY		Interval Between Onset and Death
P.O. Box 6876	ath certific ttending p or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	d	al death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	livery Day Year
	uires that the de signed by the a id be detached f	þ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	ınderlying cause gr	ven in Part I.	23e. Did tobace		o the cause of death?
Vital Records,		Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s 2 No
Vita	sician: Th certificate lirector, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ER/Outpatie	nt 3□ DOA Ot	han	ath <i>Check onli one</i> l Home 5 ☐ Residence	e 6 □Other (Spe	ecify)
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ny at ork?]Yes 2 □ No	28d. Describe how i	njury occurred	
Division	s after des s after des al Director ad in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, st	reet, factory, office		28f. Location (Stree City or Town, S		lural Route Number,
	e Hospil 24 hour e Funara	edicai (29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best of my kn iner: On the basis of examin- and manner stated.	owledge, dea ation and/or in	th occurred at the to execution, in my	me, date and place opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner a and place, and du-	s stated. e to the cause(s)
)	To the within To the comp	M	29b. Signature and title of certifier			29c. Licen	se number		Date signed (Mon.	
	5		30, Name and address of person who of	4 15	эт 23a) (Туре Э̂00/ Н	Print)	DR	CHEVER	LY MD	20185
	St	ate	31. Date filed (Month, Day, Year)	32. Registral's Sign	nature	Coerts	,	0//0		

Physician /Medical Examiner 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital Funeral Director Pure 1	2. Date of Death Month Pebruary 13, 2005 4c. County of Death Calvert 3. Date of Birth Calvert 3. Date of Birth Calvert 4. Pearl S. Date of Birth Day, Year Maryland 10d. Inside City Limits 1 \(\sqrt{Yes} \) 2\(\sqrt{N} \) No
Physician Medical Examiner	Month February 13, 2005 0135 A M 4c. Country of Death Calvert 3. Date of Birth Country Pay, Year Maryland 10d. Inside City Limits 1
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death Calvert 3. Date of Birth (Month, Pay, Year) 104, 1963 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1
Funeral Director 5. Social Security Number 2 1 3 - 8 0 - 7 6 6 4 1 1 1 M 2 F 4 1 Yrs. F	9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 □ Yes 2 ☒ No 10g. Citizen of What Country? USA
Usual Residence of Decedent	10d. Inside City Limits 1 □ Yes 2 ☑ No 10g. Citizen of What Country? USA
Usual Residence of Decedent	10d. Inside City Limits 1 □ Yes 2 ☑ No 10g. Citizen of What Country? USA
Maryland Calvert Prince Frederick 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10f. Zip Code 20678 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Process) 15. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 16. Street and Number 17. Was Decedent of Hispanic Origin? (Specific Number Origin) 17. Was Decedent of Hispanic Origin? (Specific Number Origin) 18. Was Decedent of Hispanic Origin? (Specific Number Origin) 18. Was Decedent of Hispanic Origin? (Specific Number Origin) 19. Street and Number 19.	1 □ Yes 2 No 10g. Citizen of What Country? USA
10e. Street and Number 10e. Street and Number 10f. Zip Code 20678 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Personal Property Cuban, Mexican, Puerto R	USA
168 Mason Road 206/8 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec Hyes, specify Cuban, Mexican, Puerto R	
11. Marital Status 12. Was Decedent ever in 0.5. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spec	ican etc.) Plack White etc.
The part of the pa	Specify: Black
15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
The state of the s	Construction
N posterior of the state of the	(First, Middle, Maiden Sumame)
James James Bell, Sr. Mary 19a. Informant's Name/Relationship (Type, Print), 19b. Mailing Address (Street and Number or Rural)	Ann Parker
James Bell, Sr./Father 19b. Mailing Address (Street and Number or Rural 21126 Winding Way I	Dexington Park, MD 20653
20a. Method of Disposition 1 Naurial 2 Cremation 3 Removal from State 1 Naurial 2 Cremation 3 Removal from State 1 Naurial 2 Cremation 3 Removal from State 1 Naurial 2 Cremation 3 Removal from State 1 Naurial 2 Cremation 3 Removal from State 1 Naurial 2 Naurial 2 Naurial Service Licenses 20b. Place of Disposition (Name of cemetery, crematory or other place) So. Mem. Gardens 2/19/ 22. Name and Address of Facility Sew 1451 Dares Beach	
**A Donation 5 Other (Specify) 14 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses So. Mem. Gardens 2/19/	rell Funeral Home Rd.Prince Fred.,MD20678
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest, Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) Amedical Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Onset and Death
Examiner Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury	
if any, leading to immediate cause. Enter Underfyling Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
william of the control of the contro	
The law required by the standing physicial and t	23d. Date of delivery Month Day Year
C TE TO BE T	23e. Did tobacco use contribute to the cause of death?
w requirements and the second of the second	1 Yes 2 No 3 Probably 4 Unknown
The law requires to the law requires to the law requires to page 2 should be completed by	24a. Was an autopsy findings available prior to completion of cause of death?
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
examiner? Mospital: Impatient 2 X R/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
28a. Date of Injury (Month, Day Year) 28b. Time of 1 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 1 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 1 28c. Injury at Nork? 28a. Date of Injury (Month, Day Year) 1 28c. Injury at Nork?	3d. Describe how injury occurred SUBSECT WAS JACT
Series a Series 6 Could not be	Rf. Location (Street and Number or Bural Boute Number
building, etc. (Specify) ANKING LET	City or Town, State) Calvert county fair grounds, mD
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) PARKING LIT 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number	
29b. Signature and title of certifier 29c. License number 0.C.M.E.	29d. Date signed (Month, Day, Year)
4 1001.70	February 13, 2005
30. Name and address of posson who completed cause of death (Item 23a) (Type, Print) THIS M.D. 111 Penn Street, Baltimo	re, Maryland 21201
State Registrar State Registrar 31. Date filed (Month, Day Year) FEB 1 7 2005 State Registrar Signature	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) February 14 2005 **Physician** Bertie Louise Buehler 1135 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Calvert County Nursing Home Calvert Prince Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Dec 16 19 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2QF 93 Maryland Yrs. 578 12 0870 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23e or 28e-1 show the Medical Examinativities be notified at 1 ☐ Yes 2 ☐ No Director St. Leanard Calvert Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2030 Wood Road 20685 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed withIn 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: ģ 3 XWidowed 4 ☐ Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Store Owner retail sales permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Importent: if Item 27 is marked other eny injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Wood Katie Louise Weems ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F.O. Box 112 St. Learnerd Maryland 20685 lace of Disposition (Name of Date 20 <u> William R. Buehler- son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Church Cemetery Feb 19 2005 Port Republic Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home Kausa 4405 Broomes Ts. rd. Fort Republic Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 4 years Alzheimers /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 🗀 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? res 2 No certificate 1 Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Hospitel 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D51949 2/15/05 MD person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 110 Hospital Road Prince Frederick Maryland 20678 D 31. Date filed (Month, Day Year) 32. Registras Signature State 7 2005 Registrar

			For 1 - State	State		nd / Depa	artment of	Health a	and M	-	_	Die.	a	
			Registrar			Cei	rtificate of	Death	·		g. No.	U5	0728	1
	Physicia	an	Decedent's Name (First, Middle							2. Date of Deat Month	h Day	Year	3. Time of Death	
	/Medic		Nunzio Barbe							02	36 C)S	8:48 4. V	1
	Examin	er	4a. Facility Name (If not institution	1 11	umber)		4b. City, Town,	or Location	100-)	4c. County		. 1	
			socied Hec	6. Sex	Proce	. last birthday)	If Under 1 Yea	r If Under	24 Hrs	2 Date of Pints		390		
	Funeral Director		5. Social Security Number 235–05–9525	1XXM 2□ F	7. Age (in y/s		Months Days		Min.	8. Date of Birth (Month, Day, May 24,	Year) 1919	Cour	itace (State or Foreig atry) a	n
	and		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	ocation					1	Od. Inside City Limits	s
	f sho	ō	WV Miner	a1	Ke	eyser							ty∑Yes 2 □ No	
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<u> </u>	al Hy al Oth	Be (17. Father's Name (First, Middle,	Last)						(First, Middle, M	Aaiden Sumam	ne)		
yıan	should to marked marked marked marked	2	Joseph Barbera			_				a Iezzi				
Mar	nd 2 she Ith and 27 is m		19a. Informant's Name/Relationsl Nunzio E. Barb				ng Address <i>(Stree</i> Walnut			_		State, Zip	Code)	
<u>o</u> ,	s 1 ar f Hea item othe		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of matory or other pi	ace)	Da	ate :	20c. Location -	City or To	wn, State	
Ē	Pages nert of int: If it		1 XBurial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (Si		Julia		emetery		3/01,	/05	Bayard	, WV		
Baltimore	permit. Departm Importa any inju		21. Signature of Funeral Service	icensee	Don-		2. Name and Add Markwood	Funer	cal Ho					
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	Dharistan		shock, or heart failure. List	only one cause on	each line.		DUE	11					Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	aDue to	o (or as a conse	-	NE.	1/21	414	1-11/6	VICE	-1	YEAR	
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	ding Phys th. After this funeral dir	iuo]	27. Manner of Death 1 □ Natural 5 □ Pendin	g (Mo	of Injury nth, Day Year)	28b. Time o Injury	W	ork?		8d. Describe ho	w injury occurr	ed	4	
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Division	al or Attend s after death Il Director: , id in by the f	Certification:	4 Homicide determ	buil	ding, etc. (Spec	cify)	eet, factory, office	9		City or Town		9) () F1 <u>2</u>) (rriodio ridinibor,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier 1 ☐ Certifyin (Check only one)	g Physicien: To the Examiner: On the and ma	ne best of my kr basis of examir nner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in my	time, date ar opinion, dea	nd place, a ath occurre	nd due to the ca	use(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)	
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			State of Maryland / Department of Health and I	Mental Hy	giene Reg. No	400	15	07282
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()	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1		. County of		
			North Arundel Hospital Glen Burnie 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Bir				orge's
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200		sted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working infe. DO NOT use retired)	rking	16b. k	(ind of Busi	ness/Ind	lustry
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Division o	or Attanding Phater death. Diector: After the in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To			or Rura	l Route Number,
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	To the Hospital or Attank within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurred at the time, date and death occurre					
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			1 - For State Registrar	State o	Marylan	-	artmen tificate			ınd M	_	giene Reg. No 2 (05	07283
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Vital Records,	The larate has	Completed									24a. Was autop perfo 1 \(\text{Yes} \)	an 24b ssy rmed2 2 No	Were auto prior to co death? 1 \(\sum \text{Yes} \)	opsy findings available impletion of cause of
of	To the Hospitel or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date o		ER/Outpatien 28b. Time of Injury		8c. Injury Work	r. 4 🗆 Nur	sing Hor	(Check only one 5 Resident of the control of the co	ience 6 □0	ther (Speci	fy)
Division	tel or Attences after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined		of Injury - At hong, etc. (Specify		eet, factory	, office			28f. Location (5 City or Tox	Street and Nur vn, State)	nber or Rur	al Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one)		isis of examinat		estigation,	in my op	inion, deat		ed at the time,	date and place	, and due t	o the cause(s)
	To With	2			Full		4	License 3	number 9/19	8		29d. Date sign	23/0	Day, Year)
			30. Name and address of person who concluded M. Federle 31. Date filed (Month, Day, Year)	, M.D.	Shah	Asso	ciates		L1ywo	od,	Marylar	d 2063	6	
	Sta Registr		FEB 2 5 2	2005	distrar's Signat	H A	park	,						

		•	1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H	lealth and Death		ene 0 0 5	07284
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Raymond Elijah Ba	rtholow				February	14, 2005	2:27 p M
}	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Dea	th	4c. County of Dea	
			Kensington Nursin	ıg & Reha	b.	Kensi	9			gomery
	Funeral		5. Social Security Number 6. Sex	7. Ag M 2□F	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day,	Year) 9. Bi	irthplace (State or Foreign Country)
	Director		5/8-14-0580		88 Yrs.			May 26,	1916 Wes	st Virginia
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	daryl f sho	ō	Maryland Monte	gomery	Whea	ton				1 ☐ Yes 2 🖺 No
	28a-	Director	10e. Street and Number	gomery	Wiled	10f. Zip Code		10	g. Citizen of What C	Country?
	with		3527 Edwin Stree	+		2090	2		US	
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show to Mardical Exameter must be mutified at	Funerai		12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or No-	14. Race - Am	
10	r Itan	표	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐	?	If Yes, specify Cuba	n, Mexican, Pue	rto Rican, etc.)	Black, Wh	
ğ	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2 🕱 No	Specify:		Specify: Wh	ite
20	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa	ation	nrking 1	6b. Kind of Busines	s/Industry
21	thin 99.	npie	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired)	,g		
2	ed wi	Con	12		P	lasterer			Construc	tion
Ind	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, M	aiden Sumame)	
<u>ya</u>	Men Men arke	2	Jeremiah Jasper E					n Corum		
Maryland 21215-0036	2 sh and is m	15 1	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street a	and Number or A	Rural Route Number,	City or Town, State,	Zip Code)
	l and lealth im 27 her t		Sarah Mildred Ba	rtholow/	Wife 352'		treet, Wh	neaton, MD		Town State
<u>o</u>	8 = 20 T = 20		20a. Method of Disposition 15 Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	cemetery, cre	matory or other plac	1 100	ruary 18	0c. Location - City o	r Town, State
ţ	tmentmentant:		' 4 □ Donation 5 □ Other (Specify)		-	aven Cemete			ilver Sprin	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant. The Madical Example of must be natified at once.		21. Signature of Funeral Service License	Dowlar	F. 50	rancis J. DO Univer	SCOTTINS Sity Blv	Funeral	Home Inc. 1ver Spri	ng, MD 20901
	rnysician /Medical Examiner	er.	23a. Part1. Entay the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	aEt plys Due to (or as	ine.	er the mage of dyin	g, such as cardia	ac or respiratory arre	st,	Approximate Interval Between Onset and Death
,8760,	tate be executed by sician and the burial-transit	dicai Examine	Cause (Disease of injury	Due to (or as	a consequence of):					
.O. Box 6	that the death certifics ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year
rds, P	es De	by	Part II. Other significant conditions cor	ntributing to death b	out not resulting in the u	nderlying cause give	en in Part I.	100		to the cause of death? Probably 4 □Unknown
Record	has b	Completed						24a. Was an autopsy perform	ed? prior to death?	autopsy findings available completion of cause of
Vital	iclan: Th certificate rector, pag	O	25. Was case referred to medical	-			26. Place of De	eath (Check only one		3 22.10
>	Physician: this certific ral director,	O B	examiner? 1 ☐ Yes 2X No	fospital: 1 🗌 Inpati	ent 2 ER/Outpatie	nt 3 DOA Othe	er: 4X Nursing	Home 5 ☐ Resider	nce 6 □Other (Sp	ecify)
ion of	fter ne	tion; T	27. Manner of Death 18 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time o lnjury	Worl	/ at <br Yes 2 □ No	28d. Describe how	v injury occurred	
Division	F = -	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
	Hospit 4 houn Funare Funare	edical (of my knowledge, deal of examination and/or in tated.					
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	N	1	29c. License	e number	29	d. Date signed (Mon	ith, Day, Year)
)			<i>y</i>	M. D	, V	Н5	1280		1 - i	5.05
	5+1	i	30. Name and address of person who co	empleted cause of	death (Item 23a) (Type.	Print)		C1 4	-	
			Anushiravan Dadga				cal Cent	Suite er Dr., R		MD 20852
	Sta	it <u>e</u>	31. Date filed (Month, Day, Year)		rar's Signature	act 1		,		
	Registi		FEB 1 6 20	105 Bents	rar's Signature	TO AREA				

			1 - For State Registrar	State of Marylar		artment of H			iene _{eg. No.} 005	07285
	Physici	an	Decedent's Name (First, Middle, Las	•				2. Date of Dea Month		3. Time of Death
	/Media		Ramon C.	Curry				February		12:45 AM
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or		Death	4c. County of Dea	
F.			Wilson Health (5. Social Security Number 6. Se		last birthday)	Gaithers If Under 1 Year	sburg	Hrs. 8. Date of Birth	Montgor	nery thplace (State or Foreign
	uneral rector			ĎM 2□F 73	Yrs.	Months Days		Min. (Month, Day,	Year) C	untry) 11ipines
g			Usual Residence of Decedent					Jan. 7,	1732 1111	rripines
anylar	a how	_	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
94 M	Ba-f	Director	Maryland Montgome	Ly Mo	ntgomei	y Villag	e			1 ☐ Yes 2X No
with	a or		10e. Street and Number	an de		10f. Zip Code	,	1	0g. Citizen of What Co	•
eath	ns 23	Funeral	1 St. Regis Cou	12. Was Decedent Ever in U	S 13 V	2088		2 (Specify Ves or No-	United St	
fter d	r Iten	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces?		**	in, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	Black, Whi	
036 urs a	Exan	þ	3X Widowed 4 □ Divorced	If Yes, Give Kor Year or Dates:	ea 1	☐ Yes 2€ No	Specify:		Specify: W	hite
21215-0036 sd within 72 hours affrgiene.	natu	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	ent's Usual Occupa	ation	working	16b. Kind of Business	/industry
within ene.	. Wa	mpl	Elementary/Secondary (0-12)	College (1-4 <i>o</i> r 5+)	life. L	OO NOT use retired	i)	norang		
d 21215-0036 flied within 72 hours after death with the Maryland Hygiene.	ed other than "natural", or Items 23a or 28a-f ehow event, the Medicul Examinat must be notified at		17. Father's Name (First, Middle, Last)		Sales		10 Mathada	Name (First Middle)	Aerospace	Company
	9A 0) Be	Horace Curry					Name (First, Middle, I Eella Que	valden Sumame)	
Marylan 12 should be	mark	ဥ	19a. Informant's Name/Relationship (T	voe Print)	19h Mailin	Address (Street		r Rural Route Number	City or Town State	Zin Code)
Mar ith ar	Important: If Item 27 is marked any injury or other traumatic evonce.		Susan Hartung / I			Regis Co		lontgomery		
altimore, rmit. Pages 1 ar partment of Hea	tem other		20a. Method of Disposition	20b. F	lace of Dispos	sition (Name of			20c. Location - City or	
Page lent o	ارة <u>=</u>		1 ☐ Burial 2 【XCremation 3 ☐ I `4 ☐ Donation 5 ☐ Other (Specify,			tan Crema		'eb. 14, 2005 A	lexandria,	Viroinia
mit. partr	y inju		21. Signalum of Funeral Service Licens			Name and Address	,	DeVol Fune		VIIgInia
m &&.	E & 8		1) July 12 h		10	E. Deer		r. Gaithe		20877
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death	n. Do not ente	or the mode of dying	g, such as car	diac or respiratory arre	est,	Approximate Interval Between
Phys	ician		Immediate Cause (Final disease or condition	Acut, s	mid	cas de	ali.	utari	tion.	Onset and Death
	dical niner		resulting in death)	Due to (or as a conseq	uence of):		/	ugare		
LAGI		_	Sequentially list conditions	carons	The second second	rlery	tes	laxe		
pe	sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	Teu > oil:	*				
xecul	al-trar	xan	that initiated events resulting in death) Last	Due to (or as a consequ	aence of):					
8760 ate be e	pnysician and the burial-transit	dical								
Ords, P.O. Box 68760, requires that the death certificate be executed	g pny as the	Φ :		J.						
Box bath cert	for use as	ician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of de	ivery
deat	ed for	sicia	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal		Ectopic pregnancy Other (specify)			Month	Day Year
at the	tache	Physi	9 Unknown	9 Unknown				-		
es th			Part II. Other significant conditions col	hand the	_	derlying cause give		I	acco use contribute to	
Ord requir	should	ted	camerry of	acry or	gain	We we	CC C	_ 1 Te	s 2☑No 3□Pr	obably 4 Unknown
C) ≥ ≤	8 2 St	Completed by	pulline.	pur ens	cm.	Ther	lyrike	autops	/ prior to	topsy findings available completion of cause of
	, page	ဝီ ၂	Dialutes (cusu	lendequed.	ent /	endine	suffice	perform 1 Tes 2		2 🗆 No
OT VITAI HE Physician: The la	director,	<u>m</u>	25. Was case referred to medical examiner?	lospital:		Otho	. /	Death (Check only one		12
h ys	o o	2	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 ☐ Inpatient 2 ☐	ER/Outpatient 28b. Time of		4 Mursin	g Home 5 Reside		cify)
dlng	funera	tion I	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 □ Y	? ′es 2 ∐ No	280. Describe no	w injury occurred	
UIVISION I or Attending after death. Director: After	th the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, stre				eet and Number or Ru	ıral Route Number,
al or	i.	Certification:	4 Homicide	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	State)	
To the Hospital or Attending P within 24 hours after death.	ly fille		29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sicien: To the best of my know	vledge, death	occurred at the time	e, date and pla	ace, and due to the ca	use(s) and manner as	stated.
he Hin 24	plete	Medicai	one)	ner: On the basis of examinat and manner stated.	ion and/or inve	estigation, in my op	inion, death o	ccurred at the time, da	te and place, and due	to the cause(s)
With	Com	Σ	29b. Signature and title of certifier		1	29c. License			d. Date signed (Mont	
12	41		HRabeith	rschlin	Laws	004	115	Fa	bruan	13,2005
10			30. Name and address of person who co		1	•			V	
	CAL		H. Robert Birsch 31. Date filed (Month, Day, Year)	20 dDe nietande Cianas			ue Ga	ithersburg	, Maryland	20877
R	Stat egistra	-	FEB 1 7 200		Apa	le?				

			For State Registrar	State of	Marylan		artment o			lental Hy	giene ()	05	072	286
	Dhusiai	22	1. Decedent's Name (First, Midd	le, Last)						2. Date of De. Month	Dav	Year	3. Time	of Death
	Physici /Medic		Charles	н.		Culler,				Februa	ry 16,	2005	7:00) a M
	Examin	er	4a. Facility Name (If not institution						ation of Death			nty of Death		
			Bedford Court			last hinthdayl	Silt If Under 1		pring Under 24 Hrs.	C. Data of Bid		lontgo	- 3	
	Funeral		5. Social Security Number 579-10-2024	6. Sex 1∰M 2□F	7. Age (In yrs. 86				ours Min.	8. Date of Bird (Month, Da Nov. 2	v. Year)	9. Birning Cour 8 Wash	iace (State itry)	or Foreign
	Director		Usual Residence of Decedent							1100. 2	2, 131	o wasii	1119 00	II, DC
	ytand		10a. State 10b. Count	1	10c. Cit	ty, Town or Lo	cation					1	0d. Inside	City Limits
	Mar st	tor	Maryland I	Montgomery		Silve	r Spri	ng					1 🗀 Ye	s 2 🖾 No
	or 28	Director	10e. Street and Number				10f. Zip Co	ode			10g. Citizen o	of What Cour	ntry?	
	th wi	al	3701 Interna	tional Dri	ve, Apt	t. 530	2	0906				USA		
	ems	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U rces?	.S. 13. \	Was Deceden f Yes, specify	t of Hispar Cuban, M	nic Origin? (Splexican, Puerto	pecify Yes or No Rican, etc.)	- 14. R	lace - Americ		
36	s afte	by Fu	1 ☐ Never Married 2 🔀 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	ө	T T	1 ☐ Yes XIX	No Sp	oecify:		Spec	city: Whit	:e	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show a Malical Exer in etraval be notified at	d b		d Year or Da	ates: VV VV _		dent's Usual C	ocupation			16b. Kind of	Business/In	duetor	
15		Completed	(Specify only high	est grade completed)		(Give	kind of work of DO NOT use i	lone durin	g most of worl	king	TOD. TAILS OF	D03111633/111	dustry	
12	iene. r than "	mo	Elementary/Secondary (0-12)	College (1	-4or 5+}	Owr	ner				Light	ing F	ixture	es
b	e filed withIn al Hygiene. I other than vant, I'e M.	Be C	17. Father's Name (First, Middle	, Last)				18.	Mother's Nam	e (First, Middle,				
<u>a</u>	ald be denta rked tic av	To B	Charles H. C	uller					Alta d	J. Hoope	r			
Maryland	nd 2 should be f lith and Mental R 27 is marked of r traumatic ava		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (S	treet and I	Number or Ru	ral Route Numbe	er, City or Tow	vn, State, Zip	Code)	
≥,	and 2 salth : n 27 i	10	Mary Ellen Cul	ler/ Wife		-			nal Dr	., #530,				MD 20906
ore	F is a	1 0	20a. Method of Disposition 1 Durial 2 □ Cremation	3 □Removal from 5		Place of Dispo cemetery, crer	sition (Name natory or othe	of r place)	Febru	Date lary 18,	20c. Locatio	n - City or To	wn, State	
Ĕ	Bant and Co.	١.	`4 □Donation 5 □Other (Zio	on Luth			ery 20	005	Middleto	own, Mai	yland	
Baltimore,	permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If itam 27 is marked other the any injury or other traumatic avant, Jla.		21. Signature of Funeral Service	Licensee		191 500	Univer	ddcend sity B	instyFune Slvd, W,	eral Home Silver Sp	Inc. ring, M	20901		
			23a. Part1. Enter the disease, of shock, of heart failure. Lis	r complications that a	used the deat ach line.	th. Do not ent	er the mode o	f dying, su	uch as cardiac	or respiratory as	rrest,		Approximately and a second	etween
	Physician		Immediate Cause (Final disease or condition	a Myoca	ardial	Infarc	tion						Onset and	
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):								
	LAdillilei	L	Sequentially list conditions, if any, leading to immediate	b. Coro	nary A	rtery I	Disease						Year	
	ped tist	Examiner	Cause (Disease or injury	3 Due to (or as a corrsec	querice or,						- 11		
	xecul and al-trar	xar	that initiated events resulting in death) Last	cDue to (or as a consec	quence of):								
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit			d										
687	ificate g phys	Physician/Medical		u							100000			
ŏ	death certifica attending phater use as the	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Tectonia aroa	20001			23d. [Date of delive	ary	
m.	ie deatl the atte hed for	lcla	in the past 12 months? 1 □ Yes 2 □ No		ant at time of c]Ectopic pregi] Other (speci					Month	Day	Year
P.0	that the d ed by the detached	hys	9 🗆 Unknown											
	res tha igned be det	by F	Part II. Other significant condit Chronic Obs			•	, ,	se given in	Part I.		obacco use co			
ord	w requir been si should	ted								10,	Yes 2 □ No	3 ☐ Prob	ably 4 E	Unknown
Records,	9 4 9	Completed				-				24a. Was autor perfo 1 \(\subseteq \text{Yes}	rmed?	b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	mpletion of	s available cause of
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medic examiner?	al				26.	. Place of Dea	th (Check only o		info		
of V	Physician: this certific ral director,	10	1 ☐ Yes 2 ₺ No	Hospital: 1 □ II	npatient 2	ER/Outpatier			Nursing H	ome 5 Resid	dence 6 🗆 C	Other (Specif	y)	
			27. Manner of Death 1 Natural 5 ☐ Pend	ing 28a. Date of (Month	of Injury h, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe I	now injury occ	curred		
<u>Si</u>		catl	2 Accident inves	tigation			M		2 🗆 No	206 Leastine (Chand and Alice	mhan an Dina	I Cauta Alu	
Division	in Direct	Certification:		mined 286. Place	of Injury - At h ng, etc. (Speci		еет, тастоту, о	ПСӨ		28f. Location (: City or To	vn, State)	mber or Hurz	ii Houte Nu	товг,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C		ing Physician: To the I Examiner: On the ba and mann	asis of examina									(s)
	To th within To th compl	Me	29b. Signature and litle of certification	er /	7	1411	29c. L	icense nu	mber		29d. Date sign) F
)	0			11/1	1	WY)) L	700	11		repru	ary 17	, 200	10
	12		30. Name and address of perso	who completed caus	e of death (Iter	n 23a) (Type,	Print)							
			Nakul Goyal,	M.D 3801	Intern	nationa	l Driv	e, #:	211, Si	lver Sp	ring,	Md 209	06	
	Sta Regist		31. Date filed (Month, Day, Yea	2005	egistrar's Sign	ALUTE AND	refer							
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State of Maryland / Department of Health and Mental Hygiene 07287 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 18 2005 **Physician** Virginia Maurice Cave 18:50P [™] /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Center Carroll County Hospital Westminster Carroll If Under 1 Year | If Under 24 Hrs. Months Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2X口⊈ 91 Months 213-22-4480 1913 West Virginia Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov itam 27 is markad othar than "natural", or Itams 23a or 28a-f ahov othar traumatic evant, the Medical Evantiner must be notified at Carroll Westminster 1X Yes 2 □ No MD. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 300 St. Luke's Way 21157 United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 Yes, Give 21X No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Baltimore, Maryland 21215-0036 Specify: **XX**Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental F Andrew Maurice Wilt Minnie Ashenfelter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Charles Cave/ son 3157-402 Pine Orchard Lane, Ellicott City Md 21042 of Health itam 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₹ . 1 Surial 2 ☐ Cremation 3 ☐ Removal from State ŏ Westernport Maryland permit. Page Department of Important: If any injury or once. Philos Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee a 111 Church St., Westernport, Maryland 21562 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line Immediate Cause (Final Physician benmon a disease or condition resulting in death) /Medical Due (or as a consequence of) **Examiner** an Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of Physician/Medical Examiner Ventriular Response Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Dav 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed disesse ar ter 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate ! 2 □ No 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 🗌 Yes 2 🗆 Mo 2 ER/Outpatient 3 DOA Certification: To of this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To tha Funaral Di completely filled in cal 29a. Certifie 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) East Main steet Westminster MD 21157 MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 22 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 🛭 🗍 🖔 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D3^y2 2005 **Physician** Thomas 18:44 P M Dowry Campbell February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, You Oct. 30, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**√2** № 2 □ F 217-10-5221 89 Director 1915 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits the Medical Exeminer must be nutified at MD. Anne Arundel Annapolis Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural', or Itams 23a 428 Halsev Road 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. e filed within 72 hours after il Hygiene. othar than "natural", or Ita ty⊟yes 2 No WW 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Spacify: White 1 ☐ Yes 2000 No δ Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) United States Gov. 12 Lab Assistant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is markad oth any injury or other traumatic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Campbell Annie Schramm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Smith/ nephew 428 Halsey Rd., Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 02/16, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Philos Cemetery Westernport Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 7. Wayne 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DENGUINA Alruginegre **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown d bengis .. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 20 No 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death. Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in 24 hours a Funaral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fund completely f (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of perein who completed cause of death (Item 23a) (Type, Print) Lego Okis 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			State of Maryland / De State Registrar	epartment of He			ene g. No. 005	07289
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) TOSEPH AMHOUY COMPTON 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo		Date of Death Month	Day Year 1 0 200; 4c. County of Deat	
	Funeral Director		Harford Memorial Hospital 5. Social Security Number 217-56-6938 6. Sex 1 M 2 F 7. Age (In yrs. last birtho	day) If Under 1 Year I	e de Grace Under 24 Hrs. 8. Hours Min. (Date of Birth (Month, Day, Oct. 31	Harf Year) 9. Birt Co , 1949	ord hplace (State or Foreign untry) Maryland
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	h with th		10e. Street and Number 2111 Sherwood Lane	10f. Zip Code	21078	10	g. Citizen of What Co U.S.	
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Maryland 2	wild be filled Mental Hygid arked other attic event, the	To Be Co	17. Father's Name (First, Middle, Last) Thomas Joseph Compton, Sr.		8. Mother's Name (F		aiden Sumame) DeFrank	
	es 1 an of Heal of Itam 2 or other		Sherry M. Compton (wife) 20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State 20b. Place of Disposition cemetery,	tailing Address (Street and Sherwood I sposition (Name of crematory or other place)	Lane, Havi	re de G	race, Mary	Town, State
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Dicensee	rris & Co., Inc 22. Name and Address Lee A. Patte Perryville,	of Facility erson & Sc	on Fune:	ral Home,	Pennsylvania P.A.
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	\ ⁰		30. Name and address of person who completed cause of death (Item 23a) (The second sec	PER CHESA	PEAKE	Dr. S	SUITE 20	BEL AR MANYUND 21014
	Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regi frar's Signature FEB 1 8 2005	Aprile				

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ā	al or	Certification:	4 Homicide	building, et	tc. (Specify	y)				1	City or Town	n, State)				
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			1 - For State Registrar	State of Ma	ryland / Depa	artment of rtificate of		ind Mei		ene	5	07291
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036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Extendron mult be multified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑Yes 2 □ No If Yes, Give Year or Dates:	1946-	Was Decedent of f Yes, specify Cut 1 ☐ Yes 2 ☆ No		Puerto Rici	an, etc.)		, White, א תולה	
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	Physician /Medical		23a. Part f. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line	he death. Do not ente	er the mode of dy	ing, such as c	ardiac or re	spiratory arres	t,		Approximate Interval Between Onset and Death
l	Examiner		Sequentially list conditions, b									
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for as a	consequence of).							
ó,	cate be executed physician and the burial-transit		that initiated events resulting in death) Last	Due to (or as a	consequence of):							
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O. Box (The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	ey .			23d. Date Mont		y Day Year
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I Record		Completed							24a. Was an autopsy performe	d? pr	ior to con eath?	sy findings available apletion of cause of
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ion	Attending F death. ctor: After y the funer	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury		rk?]Yes 2∐No	0				
Division of	spital or Attendours after death ours after death aral Director: , filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	eet, factory, office			Location (Stree City or Town,		r or Rural	Route Number,
	Hos 24 h	edical	(Check only 2 Medical Examin	icien: To the best of er: On the basis of e and manner state	my knowledge, death examination and/or inved.	estigation, in my	opinion, death	place, and occurred a	due to the cause t the time, date	se(s) and man and place, ar	ner as sta nd due to	ited. the cause(s)
	To the within To the comple	2	29b. Signature and title of certifier	niels	lo	29c, Licens			29d	Date signed	(Month, E	yay, Year)
			30. Name and address of person who con Struct E. Selo	mpleted cause of dea	ath (Item 23a) (Type, I	Bastgas	e Rd.	Anu	napolisi	uid.	21	401
	Sta Registr	τe	31. Date filed (Month, Day, Year) FEB 1 6 2	32. 110 Stall	's Signature	book						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Feb. 2005 10:57 PFEFFERKORN CUNNINGHAM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Center Bel Upper Chesapeake Medical Harford Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/6/1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗷 F Months Days Min Yrs. Director 219-34-6799 69 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28e-f ehov other treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Completed by Funeral Director MD. Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 1804 Celeste Road 21050 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced White "neturel" 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within in and Mental Hygiene.
7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Teacher Special Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pfefferkorn Samuel Louis Elizabeth Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21903 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any Injury or other treum <u>once</u>. L. Nelson Amos 400 Drum Point Court Perryville, Md. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State A □ Donation 5 □ Other (Specify) Carroll Cremation 3/2/2005 Hampstead, Maryland 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Severe Immediate Cause (Final ronary Disease herosclenosis Physician Covonary 104 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ estensia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred : After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A after 4 Homicide

o Division of Vital Records, Junningham,

981740

within 24 hours a To the Funeral L

DHMH 17 Rev 1/2001

ame and address of person who completed cause of death (Item 23a) (Type, Print) S. ATWOVD RD. BELAIR 21014 State Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature ar

31. Date filed (Month, Day, Year)

MAR 0 4 2005

Httending



🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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•			State State Registrar Amended 2/22/05	e of Maryland item #201	d / Depa ்/wo்)ச் ச	rtment of H	lealth and		giene 0	05 0	7293
5	o. Dhuaici		Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Tir	me of Death
	Physicia /Medic			erts	Douka			Febru	arn 16	2005 /	750 4
	Examin	er	4a. Facility Name (If not institution, give street and	d number)		4b. City, Town, or	Location of Deat	h	County		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	SDU/4 If Under 24 Hrs	8. Date of Birt	h Wild	9. Birthplace (Si	tate or Foreign
	Director		220-26-8803 ^{1□ M} 🔊	F 86	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 10/24/	1918	Country) Maryla	
	and *	}	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ration					de City Limits
	Maryla f sho	Į.	Maryland Wicomico		isbury						Yes 2 No
	r 28a	Directo	10e. Street and Number	041	.roour j	10f. Zip Code			10g. Citizen of	What Country?	
	23a o		918 Riverside Dr.			2180	01		USA		
9	should ba filed within 72 hours aftar death with tha Maryland nd Mental Hygiene. markad othar than "natural", or itams 23a or 28a-f show imatic avant, tra Nedicul Evantrat must be rediffed at	Funerai	1 Never Married 2 Married 1 1	Decedent Ever in U.: d Forces? 'es 2 X .No s, Give	li li	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2☑ No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Blac	e - American India ck, White, etc.	ın,
5-0036	ural',	d by	3 X Widowed 4 □ Divorced Year	or Dates:			. ,		Specify	WILLCO	
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D	d d d	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Suman	пе)	
Maryland	should baif nd Mental F markad ol umatic ava	٦ 2	Brady James Dayton		101 11 11			essick			
<u>8</u>	2 8 8 9 1		19a. Informant's Name/Relationship (Type, Print, Brady W. Roberts/son	'		g Address (Street a					
ē,	of Health of Health fitam 27		20a. Method of Disposition	20b. Pl		sition (Name of latory or other place		1705		City or Town, Sta	
altimore,	Pages nent of ant: If its		1 X Burial 2 ☐ Cremation 3 ☐ Removal f '4 ☐ Donation 5 ☐ Other (Specify)	IOIII SIZIE I .		Memorial	2/21		Salisb	ury, MD	
Balt	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	nes CF	HC HC	Name and Address LLOWAY F1 1 Snow H:	uneral H	ome Prof	essiona	l Associa	ation
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, 0	cate be executed physician and the burial-transit		resulting in death) Last Dur	e to (or as a consequ	ience of):						
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<u>о</u>	that the de	Phys	9 🗆 Onknown					00 0111			
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o U	ding PI	ion:	1 Aatural 5 ☐ Pending	Month, Day Year)	28b. Time of Injury	28c. Injury Work	(?	28d. Describe h	low injury occurr	ed	
Division	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. F	Place of Injury - At ho	me, farm, stre		Yes 2 □ No	28f. Location (S	treet and Numb	er or Rural Route	Number.
á	s after s after all Dira	Certification:	4 Homicide determined b	uilding, etc. (Specify	')			City or Tow			
	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: After this certifics completely filled in by the funeral director.	edicai (29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the and	the best of my know he basis of examinat manner stated.	wledge, death ion and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occu	e, and due to the durred at the time, d	cause(s) and ma date and place, a	nner as stated. and due to the cau	ISO(S)
	To the within To the	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed	(Month, Day, Yea	ar)
1	. (1 aul Koteller			224	872	-	2/14/	05	
/	13/10		30 Name and address of person who completed 1 AUL FLEURY 303	cause of death (Item	23a) (Type, F	Print)	e44,	40 2	185/		
**	Sta Registr		31. Date filed (Month FEB 2005	cause of death (Item Thuth 57 32. Registrar's Signat	Ure /	back	/				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** Year David Dawson FEBRUARY 25 /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND
If Under 1 Year | If Under 24 Hrs. ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Jul 11, **Funeral** Birthplace (State or Foreign Country) 1**√** M 2□ F Months Days Hours Director 232-72-9620 58 1946 MD Usual Residence of Decedent the Maryland 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show od other than "natural", or itams 23s or 28a-1 show event, I've Madical Examiner must be notified at WV Mineral Wiley Ford Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 316 26767 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than ¹ any injury or other traumatic event. ■ ■ Marked Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Dawson's Garage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David T. Dawson ၉ Charlotte Mae (Barkley) Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Propst nephew Rt. 3 Box 398 Ridgelev WV 26753 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State Mt. Zion Cemeterv 3/1/2005 4 ☐ Donation 5 ☐ Other (Specify) WV Short Gap 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate dause (Final disease or condition resulting in death) Physician INTRACRANIAL BLEED /Medical Due to (or as a consequence of): **Examiner** b. CARDIOPULMONARY ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. by Physician/Medical as the l IF FEMALE: esn If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ĺ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 X No 1 Yes 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division Injury 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 / Homicide To the Hospital 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D0062429 FEBRUARY 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. AQEEL SALEEM, 500 MEMORIAL AVE., CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) State Registrar MAR 04 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend#2 per Phy. State of Maryland / Department of Health and Mental Hygiene 1- State 2/16/05 AACO Health Dept. onh Certificate of Death Reg. No. 2005_{/eer} 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Margaret /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Anne Arundel Glen Burnie 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) **Funeral** Days 1 M 2 XF Months 317-09-3219 Yrs. Director 89 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show or other traumatic event, the Madical Examiner must be notified a MD Completed by Funeral Director Anne Arundel 1 ☐ Yes 2 ☑ No Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Dale Road Items 23a 21108 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö White 1 ☐ Yes 2 ▼ No Specify 3 ₩idowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chrysler Corp. Parts Division 10 other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental ent: If Item 27 is marked o Joseph Choka Anna Orsy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If Item 27 is eny injury or other transpace. Richard Ellis/Son 408 Dale Road, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 19, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State White Chapel Cemetery Troy, MI 1 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility arranco & Sons, P.A. Severna Park Funeral Home Cov. Ritchie Hwy, Severna Park, MD 21146 21. Signalure of Funeral Service Lisenses 23a. Peorl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death 10040 car Tarchon **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannes of Death 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D25611 mo 7845 Dakwad Rd #300 Glen Burnie md 21061 Ira E. Kaplan

State Registrar

AED TO SOO

31. Date filed (Month, Day, Year)

32. Resistrar's Signature

			1 - For State Registrar	State of M	laryland / De <i>C</i>	partment of F e <i>rtificate of</i> a			ene g. No. 005	07296
	Physic	an	1. Decedent's Name (First, Middle, Las	it)				2. Date of Death Month		3. Time of Death
	/Medi		Sadie Lee Ewell					Feb.	11, 200	
	Examir	ier	4a. Facility Name (If not institution, give)	4b. City, Town, o	r Location of De	ath	4c. County of De	ath
	Funeral		Genesis ElderCar 5. Social Security Number 6. Se		ge (In yrs. last birthda		na Park	rs. 9 Date of Birth	0.0	Arundel
	Director			☐M 2 ∏ F	87 Yrs.	Months Days	Hours Mi		Year) 1917	irthplace (State or Foreign Country) MD
	p .		Usual Residence of Decedent 10a. State 10b. County		10- Cit. T					
	Aaryla I shov	ō	MD Anne Ar	undel	10c. City, Town or		a Park			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-	Director	10e. Street and Number			10f. Zip Code	a rark	10	g. Citizen of What (
	h with	ai Di	24 Truckhouse Ro	ad		211	46		USA	•
	ams ams	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cuba	lispanic Origin?	(Specify Yes or No-	14. Race - An	nerican Indian,
36	s afte	by Fu	1 Never Married 2 Married	1 ∐Yes 2 🔀 If Yes, Give	ONo	1 ☐ Yes 2 X No		ento riicani, etc.)	Black, Wh Specify:	hite, etc. hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Madical Examiner must be notified at		3 XWidowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	162 Do	edent's Usual Occup	ation			
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ē,	nit. Pages 1 and 2 should artment of Health and Men ortant: If item 27 is marka injury or other traumatic 8.		20a. Method of Disposition		20b. Place of Dis	position (Name of		Date 20	c. Location - City o	
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	Physician ¹		Immediate Cause (Final disease or condition	nie cause on eagin) h 014		`~			Onset and Death
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	Physici /Medic Examir	cal	Decedent's Name (First, Middle, La:	ro Evans	4b. City,	Town, or Location	2. Date of Dea Month	Day Year 17 200 4c. County of De	50338 M
	Funeral Director		5. Social Security Number 6. S	Nemorical ex Memorical om XXF 7. Age (In yrs. Ia 91	st birthfry) If Unde Months		24 Mrs. 8. Date of Birth (Month, Day 11 - 15 - 1	() () () () () () () () () () () () () (rthplace (State or Foreign country)
	death with the Maryland ims 23a or 28s-f show f must be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County WV Tucker	10c. City, Davi					10d. Inside City Limits XXYes 2 □ No
	ath with the 23a or 2	by Funeral Director	Thomas Avenue	12. Was Decedent Ever in U.S	10f. Zip	26260		U.S. A.	
5-0036	72 hours after de natural', or item ilical Examinar	d by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, spe		igin? (Specify Yes or No- n, Puerto Rican, etc.)	Specify: [nte, etc. White
21215-(should be filled within 72 hours nd Mental Hygiene. marked other then "natural!, i imatic event, the Medical Exa	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	16a. Decedent's Usu (Give kind of wo life. DO NOT u Housekee	ork done during mos ise retired)		Blackwat State Par	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified as	To Be (17. Father's Name (First, Middle, Last) Foster F 19a. Informant's Name/Relationship (1)		19b. Mailing Address	Susi	er's Name (First, Middle, 1 <u>e Martin H</u> er or Rural Route Numbel	Hartley M	
	ages 1 and 2 sint of Health and Elit item 27 is recorded traur		Wayne Mullenax 20a. Method of Disposition 1 Deural 2 Cremation 3 C	Removal from State 20b. Pla	1360 Ghe	en Rd.	Salisbury,	NC 2814 20c. Location - City o	r Town, State
Baltimore,	permit. Pages 1 an Department of Heat Important: If Item 2 eny injury or other gnce.		* 4 Donation 5 Other (Specify 21. Signature of Funer I Service Licen		ris Cemet Finkl F.O. B	ery 2 nd Address of Facility e Tuner ox 186	-19-2005 ål Home, I Davis, WV	Davis, W Inc. 26260	V
1	Physician /Medical		23a. Part1. Enter the disease, or compands, or compands, or condition the condition condition resulting in death)	olications that caused the death. a	dial		cardiac or respiratory arr	est,	Approximate Interval Between Onset and Death
8760,	iste be executed by solution and inhysicien and inhe buriel-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of knight) that initiated events resulting in death) Last	Due to (or as a conseque Due to (or as a conseque					
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o	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director. page.	tion; To B	examiner? 1 Yes 2 No 27. Manneyof Death Watural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	R/Outpatient 3 DO	0.1	rsing Home 5 Reside		ocify)
Division	itel or Attending irs after death. rai Director: After led in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined					reet and Number or R n, State)	ural Route Number,
	To the Hospitel within 24 hours and the Funeral completely filled	Medicai	29a. Certifier (Check only one) Certifying Ph 2 ☐ Medical Exam 29b. Signature and title of certifier	ysician: To the best of my knowl iner: On the basis of examinatio and manner stated.	on and/or investigation	at the time, date and, in my opinion, deal	th occurred at the time, da	ause(s) and manner a ate and place, and du 9d. Date signed (Mon	e to the cause(s)
	¥3¥8		30. Name and address of person who	completed cause of death (Item 2	No	H761	157	2/17	105
	Sta Registr		PDans Letter (Month, Day, Year) MAR 0 3 200	32 Registrar's Signatu	× 696) (tel)	zoes Dr. (Dakler	2130

State of Maryland / Department of Health and Mental Hygiene 115 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** divard 6:36 2005 renda ebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Oeath Examiner If Under 24 Hrs. Johns 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) A SAX **Funeral** Months Days Hours Min 1 □ M 2X F 224-54-2945 Director 63 JAN 1942 Washington DC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heatth and Mental Hygiena. Interest of them 23 a or 28a-f ehow int: if item 27 is marked other then "natural", or items 23a or 28a-f ehow into organizer must be rotified at into organizer must be rotified at 1 ☐ Yes 2 X No Maryland Prince George's Upper Marlboro Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 4603 Penzance Place United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Rusiness/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 School Bus Driver Public County Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Denze1 Carrico Madelyn Burton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20234 Birdsnest Place, Ashburn, Virginia 20147 Jennifer Griffin / Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition matory`or other pla Virginia Northern Virginia Funeral Services 1 Burial 2 Cremation 3 Nemoval from State permit. Page Department of Important: If eny injury og FEB 16,2005 Chantilly, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Northern Virginia Funeral Services 21. Signature of Funeral Service Licenses 14522L Lee Road, Chantilly, VA 20151 M00956 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Arachnoid JUD days /Medical Due to (or as a consequence of): **Examiner** Aneurysm Due to (or as a consequence of) unknown Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 2 No 3 Probably 1 ☐ Yes 4 | Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an certificate has 1 Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient Certification: To 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 TYes 2 No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Viete 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific RES-000 February 12, 2005 M.D 20 Launcey lones, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St., Baltimore, MD 600 Wolfe Chauncey T. Jones, M.D., 31. Date filed (Mon 16 State 2005 Registrar

			For State Registrar		Marylan		artment tificate			and M		Reg. No.		5	072	99
	Physici	an	1. Decedent's Name (First, Middle, La Cecelia B. Fel:	·							2. Date of Dea	ath Day	5, 20°	ear	3. Time of 0	
	/Medic Examin		4a. Facility Name (If not institution, gir	ve street and num	nber)				Location o		1 CDI GG	4c.	County of	Death		•
			Holy Cross Hopsi		7	for a filling of the state of t	Silv If Under		Sprine If Under		0.000		ntgom			
	Funeral Director			Sex 1 M 2 F	7. Age (In yrs. 8	8 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da June 15	y, Year) 191	6 N	Coun EW	lace (State or stry) York, I	N.Y.
	death with the Maryland ms 23a or 28a-f ehow Frivist be rictified at	tor	10a. State 10b. County Maryland Montgor	nery	10c. Cit	y, Town or Lo Silve		ing						1	0d. Inside City 1 ☐ Yes	•
	3a or 28a	Il Director	10e. Street and Number 3114 Gracefield 1	Road, #2	10		10f. Zip		20904				zen of Wha ted S			
336	be filed within 72 hours after death with the Marylan ital Hygiene. id other then "naturel", or Items 23a or 28a-f ehow event, The Madical Exarchise must be ricilited at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 Tes If Yes, Give Year or Da	2 🔯 No e	ł	Was Deced f Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe	cify Yes or No- Rican, etc.)	-	I4. Race - Black, Specify:			e
9500-6121	within 72 hor ene. then "nature he Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-	-4or 5+)		kind of wor DO NOT us	k done d e retired,	ation furing most	t of worki	ng		nd of Busin		lustry	
707	filed v If Hygie other t	Be Co	12 17. Father's Name (First, Middle, Las			HOME	maker				(First, Middle,		wn ho Sumame)	me_		
yland	should be nd Mental marked c	ToB	Charles E. Butler				175.7				White					
Mar	nd 2 sh alth and 27 io m ir troum		19a. Informant's Name/Relationship Andrew B. Felix								i Route Numbe					904
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumatic sons.	l Y	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 [State Met	lace of Dispo emetery, crem	sition (Name natory or ot	ne of ther place	etory		ate 5/2005		cation - Cit			ni a
altill	mit. P.		4 □ Donation 5 □ Other (Special Signature of 10 ral Service Lice		0	-			1		Funeral				virgi	ша
מ	83588		23a. Part1. Enter the disease, or con	Acata	aused the death	44	00 Po	wder	Mil.	l Roa	d Belts	svil.	le, M	ary.		
	Pnysician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on ea	D		or the mode	or dying	g, 30011 kg	ourdiuc o	r respiratory ar	1631,			Approximate Interval Betwoonset and De Week	een eath
	Examiner		Securation list conditions	Pne	or as a consequ umonia										1 week	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on injury)	Due to (c Rena	oras a consequ al Fail	uence of): 1111°C										
8/00,	certificate be executed adding physician and use as the burial-transit	al Exar	that initiated events resulting in death) Last	C. Due to (c	or as a consequ	uence of):				· · · · ·		. <u>-</u>				
Õ	rtificate ng phys as the	Medical	IF FEMALE:	d												
C. BOX	death e atter	hysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		nth 2 □ Fetal ant at time of de	Ideath 3	Ectopic pre Other (spe					2	3d. Date of Month			ear
rds, P.	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions	contributing to de	ath but not resi	ulting in the ur	nderlying ca	ause give	en in Part I.			obacco u	_		e cause of dea	
II Kecoras	The law ate has b page 2 sl	Completed										an isy rmad? 2 XNo	24b. Wer prior deat	to con	osy findings av	vailable use of
VII		o Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes \(2 \sum \) Yio	Hospital:		FD/0		_ Othe			(Check only o				== 250	
on or		 -	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date o (Month		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	4 140	2	ne 5 🗌 Resid			Specify)	
DIVISION	el or Atter s after dea il Director d in by the	Certification:	3 Suicide 6 Could not to determined	28e. Place	of Injury - At ho ng, etc. (Specify		eet, factory,	, office		2	28f. Location (S City or Tow		l Number o	r Rura	Route Number	er,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical C	29a. Certifier	hysician: To the miner: On the ba and mann	sis of examinat	wledge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date an	d place, a	and due to the ded at the time, d	cause(s) date and	and manne place, and	or as sta	ated. the cause(s)	
	Totl within Totl	Me	29b. Signature and title of certifier	Huma	ang.	HD	29c.	D59	number 524		:	^{29d. Date} Febr	signed (M ruary	16,	Day, Year) 2005	
	15		30. Name and address of person who Loveen Puthumana	, MD 311	0 Grac	efield	Road	Sil	ver S	Sprin	g, Mary	vlanc	2090)4		
1	Sta Registr	_	31. Date filed (Month, Day, Year) FEB 1 7 20	05 Ber	agistrar's Signa	ture	de)									

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			1 - For State Registrar		,		rtificate o			-	Reg. No. 20	05	07300
	Physici	an	1. Decedent's Name (First, Middle, L	ast)						2. Date of De Month	Day	Year	3. Time of Death
	/Media	cal	Hugh 4a. Eacility Name (If not institution, g.	S.	Frie	end	4b. City. Town	or Location o		Februa	ary 27,	200	51001
	Examir	ner	Socred Hel	art Ho	spita	21	CAA	mber	-10	nd	All	ega	nu
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. las		If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Bird (Month, Da Jul 10,		9. Birthpla	ace (9 ate or Foreign
	Director		220-34-1783 Usual Residence of Decedent	1 M 2 F	66	Yrs.				Jul 10,	1938	Countr	ID .
	yland now		10a. State 10b. County		10c. City,							10	d. Inside City Limits
	s within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-1 ahow the Medical Examinar must be rodified at	Funeral Director	MD Allega	iny		Cumb	perland						1√Yes 2 No
	with the	Dire	10e. Street and Number				10f. Zip Code	21502	,		10g. Citizen of V		ry?
	death ms 23	eral	405 Linden Stree 11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent of Yes, specify Co			cify Yes or No		e · America	
9	or Ite	/ Fur	1 Never Married 2 Married	Armed Forces? 1 Yes 2 If Yes, Give	Vo		f Yes, specify Ci 1 □ Yes 2🖔 N		, Puerto	Rican, etc.)	Specify	k, White, et	
003	hours tural;	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	1955-5		dent's Usual Occ		-		16b. Kind of Bu	white	
215	within 72 ene. than "nai	Completed	(Specify only highest g			(Give	kind of work don DO NOT use reti	ne during most red)	of working	ng	166. Killa of bu	sinessyindu	asily
212		Com	12			aintir	g Contra				Self-emp		
and	be de la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Las							(First, Middle, Riffle I	Maiden Sumam Eriond	θ)	
Maryland 21215-0036	d 2 should by and Ment 7 is marked treumatic	10	Hugh M. Friend 19a. Informant's Name/Relationship			19b. Mailir	ng Address (Stre				or, City or Town,	State, Zip (Code)
	12 ha 7 is		Ann Friend	wife	. 1		Linden S			-	erland		21502
Baltimore,	f f		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3	☐Removal from State			sition (Name of natory or other p			ate	20c. Location -		
tim	Pa men ant:		*4 □ Donation 5 □ Other (Special Signature of Funeral Service Liquidad)	city)	Davis		orial Ceme			3/2/2005	Cumbe	rland	MD
Ba	permit. Departr Importe any inji		21. Signature di Funeral Selvice Liq)-MM	,		Name and Add				t d MD (24500	
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused	I the death.	Do not ent	er the mode of d	ying, such as	cardiac o	r respiratory ar	land, MD 2	i	Approximate Interval Between
	Pnysician		Immediate cause (Final disease or condition	a MASS	Ne		Lebe			Accis	lent		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque								
		er	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying	b. Due to (or as	a čuriodyum	ice of).							
V	be executed sician and burial-transit	Examiner	that initiated events	C									
760,	ite be exe ysician ai ne burial-t		resulting in death) Last	Due to (or as	a conseque	nce of):							
687	A > 0	edicai		d									
Box (death certificat e attending phy d for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			3=i.				23d. Date	e of delivery	/
	ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at			Ectopic pregnar Other (specify)				Mon	ith D	Day Year
P.0	that the de led by the a detached t		9 ☐ Unknown Part II. Other significant conditions		ut not fesulti	na in the u	aderiving cause o	uven in Part I		23e. Did to	bacco use contri	ibute to the	cause of death?
ds,	igi es	d by	-10/	PROSUR	M	DRC	11	145		1 🗆 Y	_/		bly 4 □Unknown
Records,	s been s should	olete	Hypertens	IDN						24a. Was	an 24b. W	Vere autops	sy findings available
Re	The lav	Completed								autop perfor	med? d	rior to comp eath? Yes 2	pletion of cause of
Vital	ysician: This certificate director, pag	Be	25. Was case referred to medical examiner?		/				of Death	(Check only o			
of/	9 9 5	.To	1 ☐ Yes 2 ☑ No 27. Mann Death	Hospital: 1 Inpatie	nt 2 EF	VOutpatien	t 3 DOA 28c. Inj		-		ence 6 Othe		
E C	iling After fune	tlon	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Da	Year)	Injury	W	ork? □Yes 2□N		.00. 0000.100	ow injury occurre		
Division	r Attendi er death. rector: A by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not determine		ury - At home	e, farm, str	eet, factory, office	8	2	8f. Location (S City or Tow	treet and Numbe	r or Rural F	Route Number,
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	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hysicien: To the best miner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the restigation, in my	time, date and opinion, deat	d place, a h occurre	nd due to the o ad at the time, o	ause(s) and mar late and place, a	ner as state nd due to th	ted. he cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	4,1			29c. Lice	nse number			29d. Date signed	(Month, Da	ay, Year)
			· Mu	loan	em	M)2;	210	81 1	ChRUN	My 5	8 2005
	N.		30. Name and address of person who	completed cause of d		3a) (Type,	Print)	رب (ا	Cir	horton	Chryn id, MI	Sie	203
	Sta	to.	JR. Gary Wagon 31. Date filed (Month, Day, Year)		Bish ar's Signatur		CK-214 K	י בוינה	CUIT	الكال الحمدال	10,101	ا مر	
	Registr			005	. 1	A	esto a						

4)	, ,		For State Registrar	State of	Marylan		artmen rtificat					giene	0.0 r	•	07301
			Decedent's Name (First, Middle, L.)	ast)							2. Date of Dea	ath		21	3. Time of Death
	Physicia /Medic		Bruce Kendall	Fink		···					Februar		5, 200)5	3:18 P M
	Examin		4a. Fecility Name (If not institution, g 1426 Glenville		er)				Location of			4c.	County of E		-
					Age (In yrs.	last birthdav)		Vre (de Gr		8. Date of Birt	h	Harf		
	Funeral Director		508-84-3831	1⊠M 2□F	42	-	Months	Days	Hours	Min.	8. Date of Birt (Month, Pa 9/22/6	y Year) 2			ace (State or Foreign ry) Onsin
-	D .		Usual Residence of Decedent												
	show	5	MD Harf	ord		y, Town or Lo lavre d		CO						10	d. Inside City Limits 1 Yes 2 No
	the N	Director	10e. Street and Number	OLG	1	avic c	10f. Zip				T	10g. Citi	izen of Wha	t Couni	ry?
	3a or		1714 Glenville	Road				078				Ü	.S.A.		
	death	Funeral	11. Marital Status	12. Was Decede		S. 13.	Was Deced	tent of His	spanic Ori	igin? (Spe	cify Yes or No Rican, etc.)	-	14. Race - A		
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2-002e	a filed within 72 hours after death with the Maryland Il Hygiene. Other than "natural", or Items 23a or 28a-f show vent, the Medical Examinar must be notified at		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's		es: 1 203		dent's Usua	al Occupa	ition			16b. Ki	nd of Busin		
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2	id 2 sl lth an 27 ls r traur		Lorie L. Fink								łavre d				0000)
ē,	s 1 ar f Hee item other		20a. Method of Disposition		20b. P	Place of Dispo emetery, cre	osition (Nar	ne of			ate		cation - City		vn, State
Ē	Pegenent o		1 □ Burial 2 🛣 Cremation 3 ' 4 □ Donation 5 □ Other (Spe			A. Fe			Ď.	3/3/0)5	Wes	t Che	ste	c, PA
baitimore,	permit. Peges 1 and 2 should be Department of Heelth and Menta Important: If tiem 27 Is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Lic	2001	ma						al Hom 21001				
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ecords,	sen si										1 🗆 `	Yes 2,	No 3[Proba	ably 4 □Unknown
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Vital H											1 Yes	2 No	1 🗆		2□ No
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000	tending F death. tor; After the funera	atlo	1 □ Natural 5 □ Pending 2 □ Accident investiga	ion Found 2	4 4	Formal 1	5.com		Yes 2 💢	No	Subject	f sh	UT 5	u	1
UNISION	I or Attending Physician: after death. Director: After this certific I in by the funeral director.	Certification;	3 Suicide 6 ☐ Could no 4 ☐ Homicide determin		f Injury - At h	y)	_		deuc		City or Tox	vn, State	11466 (Rural	Route Number, Ville Road
	To the Hospital or Attan within 24 hours after deatl To the Funeral Diractor; completely filled in by the		29a. Certifier 1 ☐ Certifying	Physician: To the b	Dall	yara			.,		and due to the			U as et	ated
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	To the l within 2. To the complet	Me	29b. Signature and title of certifier		4 4		29	c. License	number			29d. Dai	te signed (A	fonth, L	Dey, Year)
			> Calvin	Ulle	Ali	_		OCI	Æ			Feb	ruary	26	, 2005
	1341		30. Name and address of person with a street of the street	no completed cause	of death (Iter	n 23a) (Type,		l Per	nn St	reet	Balti	more	, Mar	yla	nd 21201
100	.Sta Registr		31. Date filed (Month, Day, Year) MAR 0 4	2005 32. 8	istrar's Signa	ature	best	9							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2005 7:45 Helen Lucille Foster February 18, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's 43988 Blake Creek Road Valley Lee | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or F. Country) | National Country | Washington, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🖾 F Yrs. 82 Director 577-26-1534 Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Exertines must be notified at 1 ☐ Yes 2 ☑ No Director Maryland St. Mary's Valley Lee 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 43988 Blake Creek Road 20692 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Exact 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Ď 3 ☑ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Office Manager US Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph Earl Richards Dorothy Lucille Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Son 43976 Blake Creek Rd. Valley Lee, MD Charles Robert Foster 20692 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 25, 2005 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 25, Maryland Veterans Cemetery Cheltenham, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Sign Jure of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Left breas **Physician** etas /Medical Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 physician Physician/Medical signed by the attending d be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 □Unknown 1 ☐ Yes been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 No 1 Yes Division of Vital il or Attending Phyalcian: after death. Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 D ome 5 A Residence 6 ☐ Other (Specify)
28d. Pesc ibe how injury occurred 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of ath 28b. Time of 28c. injury at Work? Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D19911 10 94.0 5 O ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete James C. Boyd, M.D., 23415 Three Notch Road, California, MD 20619 31. Date filed (Month, Day, Year) 32. Begistr s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie [] [] 5 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 2 3. Time of Death **Physician** 2005 1837 FRANCES ELIZABETH FERRIN /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Berlin Atlantic General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2X F 82 Yre MD 12/25/1922 Director 220-14-8107 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State or 28a-f ahov other traumatic event, the Medical Examiner must be nutified at 1 Yes 2 No Funeral Director MD Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21811 11 Fishermans Dr. or Itams 23a 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or Its 1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Eichert 2 James McDairmant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 la any Injury or other trau once. 11 Fishermans Dr. Berlin, MD 21811 Edward Ferrin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/17985 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Crematory Frankford, DE * 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Farine Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St. Berlin, MD FUU 23a. Part 1. Enter the disease, or complicitly institute caused the learn. Do no shock, or heart failure. List only an cause on each line. enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between nset and Death Immediate Cause (Final Physician 10145 disease or condition resulting in death) /Medical Due to (gras a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit 68760, Physician/Medical IF FEMALE: 23c. If yes, nutcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use coptribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Certification; To Be Completed by 1 Yes 2 12 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Mo 2 10 No 1 Yes Division of Vital 25. Was case referred to medical examiner?
1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural after death.

Director: Af 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signatore and title of certifie

C.41.5

TC-56-61

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State Registrar death (Item 23a) (Type, Pant)

				1- For Amend Item 25,25, of Maryland & Department of Health and No. 1- State Registrar Certificate of Death	-	9	07301
							0/304
		Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year_	3. Time of Death
		/Medic		ERMA MAE FLUHARTY	tebruar		2025 M
		Examir	ner	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death According 1 HOSDI FOLIA CT FOSTO EQSTO		4c. County of Death	a contract of the contract of
				Mcmorial Hospital at Easton Easton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth		
	п	Funeral Director		218-24-4721 1 M 2X F 76 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) AUG 2 19	28 MARV	place (State or Foreign Intry) LAND
				Usual Residence of Decedent	2,000 2 25	20 THAT	DIGID
		rylan thow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		e Ma	cto	MD TALBOT EASTON			1 XYes 2 □ No
)		ours after death with the Marylan ral', or Itams 23a or 28e-1 show Examirer must be notified at	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	ntry?
d		ath w	'a	1103 S. WASHINGTON ST. 21601		USA	
8		er de Itam	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
I	36	rs aft	by F	1 □ Never Married 2 ሺ Married 1 □ Yes 2 ሺ No 1 □ Yes Give 1 □ Yes 2 ሺ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify: W	HITE
ω	9	72 hours "natural",			16	Sb. Kind of Business/li	
7	7.2	nin 72 in "in	ple	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing		
t	21	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or Items 23a or 28e-1 show ant, tre Medical Examirer must be notified at	Completed	4 0 HOMEMAKER		OWN HOME	
B	nd	be filed within 72 ho ital Hygiene. id othar than "natui evant, ire Medical	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma	uiden Sumame)	
5	yla	2 should be filed within and Mental Hygiene. Is marked other then reumatic event, the M	ြို	GEORGE W. MCCARTY, SR. JULIA W	HITBY		
7	Maryland	- a s =		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Number, (City or Town, State, Zi	o Code)
T	e,	t an teal teal ther				ON, MD 216	
	ŏ	Pages nent of H int: If its iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, crematory or other place)	Date 20	c. Location - City or T	own, State
	Baltimor	permit. Pag Department Important: I any injury o	100	* 4 □ Donation 5 □ Other (Specify) WOODLAWN MEMORIAL PARK 2-1 21. Signature of Fundval Service Licensee 22. Name and Address of Facility	9-2005_1	EASTON, MA	RYLAND
	Ba	permit. Pag Department Important: I any injury o		MA FINAL TO CEST FELLOWS, HELFENBEIN	& NEWNAN	M FINERAL	HOME PA
				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or bear failure. Life only one cause on each lie of the control of	EASTON, N	(ID 21601	Approximate
		D		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	or respiratory arres		Interval Between Onset and Death
		Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of);			
1	3	Examiner		urinary tract in lection	101		
-	8		Jer	Sequentially list conditions, b. Due to (or as a consequence of):	<i>////</i>		
		cuted od ransit	Examiner	Cause (Disease or injury that initiated events	1 Jul	DICAL EXAMINER	
	760,	te be executed ysician and e burial-transit		resulting in death) Last Due to (or as a consequence of):	ON APPROVED BY ME		
	978	# % e	llcal	dCERTIFICE			
	x 68	leath certifical attending phy I for use as th	Med	IF FEMALE:			
5	Вох	attend attend for us	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
+		he de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			,
Ţ	P.0	that the detected	by Physiclan/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
30.4	rds	quires n signe ald be		ileus VS. Small Bouel obstruction	1 🔲 Yes	2 □ No 3 □ Prol	pably 4 Dunknown
7	Records,	Physicien: The law requires that the death certifica this certificate has been signed by the attending ph al director, page 2 should be detached for use as th	Completed	acute Rend faithure	24a. Was an autopsy	24b. Were auto	ppsy findings available mpletion of cause of
T	E	: The I	Cor	Digoxin toxicity	performe		2 🗆 No
1	Vital	lysicien: Th iis certificate director, pag	Be	examiner?	(Check only one)		
	o		1: 10	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how	e 6 ☐Other (Special	y)
14		Attending Ph r death. actor: After th by the funeral	Certification:	1. ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	20d. Describe now	injury occurred	
0	Division	al or Attendi after death. I Diractor: A d in by the fu	fica	3 Suicide 6 Could not be	28f. Location (Stree	et and Number or Rura	al Route Number.
10	Di	2 5 5 0	erti	4 ☐ Homicide building, etc. (Specify)	City or Town, S	State)	
T		Hospital (24 hours at Funaral Distely filled i	edical (29a. Certifier (Check only Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred.)	and due to the caus	se(s) and manner as s	tated.
14		To tha Hos within 24 ho To tha Funi completely f	Med	and manner stated. 29b. Signature and title of certifier 29c. License number		. Date signed (Month,	
		7 × 5 8		Harou Im D 55484	-	2 - 15-	
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		- /3 -	2005
		1) 1		
		Sta		H. LAURA JIN M.D. 219 S. WASHINGTON ST EASTON, MD 2160 31. Date filed (Monte EB) Year) 7 2005 32. Flistrar's Signature.	<u>/1</u>		
		Registr	ar	First room Noom of Marie			

		_	For State Registrar	State of M	aryland / Depa	artment of H rtificate of L			giene leg. No. 0 (05 07305
	Physici /Medic		Decedent's Name (First, Midd Timmy	T. Gross				2. Date of Dea		2005 9:15 P M
}	Examin		4a. Facility Name (If not institution 8200 PERRY HALL)	4b. City, Town, or ROSEDALI	Location of Death		4c. County BALT	y of Death TIMORE CO
	Funeral Director		5. Social Security Number 337-64-5519	6. Sex 7. Ag	ge (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov. 19	Year) 1962	Birthplace (State or Foreign Country) Mississippi
	pug *		Usual Residence of Decedent 10a, State 10b, County	,	10c. City, Town or Lo	ocation				10d. Inside City Limits
	/anyig	ō								1 ▼ Yes 2 □ No
	the the 288-	Director	Md. Hari 10e. Street and Number	ora	Ве	1camp 10f. Zip Code			10g. Citizen of	What Country?
	3e or		1305 Lirion	e Ct.		210	17		U.S	
	eme 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-		ce - American Indian, ck, White, etc.
36	72 hours after death with the Maryland natural', or Iteme 23e or 28e-f ahow Josal Exartmust bearediffed at	by Fu	1 Never Married Mar	ried 1XXX/es 2 ☐	[№] 1986-	1 ☐ Yes 2 No	Specify:	r noan, etc.,		y: Black
5-0036	hours tural'	ed b	3 Widowed 4 Divorced	Year or Dates:	2005	dent's Usual Occupa	ation			usiness/Industry
7.	in 72 n "na	Completed	(Specify only highe	st grade completed)	(Give	kind of work done a DO NOT use retired,	luring most of work	ting	TOD. KING OF B	usiness/industry
2121	d within giene. er then "	mo	Elementary/Secondary (0-12)	College (1-4or		Soldier			U.S.A	rmy
p	al Hy al othe	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Nam	e (First, Middle,	Maiden Sumar	ne)
Maryland	d 2 should be filed within h and Mental Hyglene. 7 le marked other then "treumetic event, It ⊾ Max	ပို	Albert	Gross			Annie		wyer	
Mar	12 sh h and 7 le m treum		19a. Informant's Name/Relation:			ng Address (Street a				
	1 and Health tem 27 other tr		Janice D. Gros 20a. Method of Disposition	s (wire)	20b. Place of Disponsional Commetery, crem			elcamp,		LO17 - City or Town, State
ЮT	Pages nent of a ant: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		Park Home		ı	-2005	LaGrand	ge Park, IL.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Iteme 23e or 28e-1 ahow among injury or other treumetic event, It is Marical Examination and once.		21. Signature of Funeral Service		/	Name and Addres	s of Facility uneral He	ome & Cr	emator	ium,P.A.
			23a. Part1. Enter the disease, o	r complications that cause	d the death. Do not ent	O1 Cleve1 er the mode of dying				Approximate
W	Pnysician		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on each I		shot Wo	nund of	Mend		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	s a consequence of):	21101 WC	una or	Hall		
	Examiner		Sequentially list conditions,	b						
	be is	iner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of.					
	The law requires that the death certificate be executed the sabeen signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	e be e sician buria	alE								
189	ifficate g phy as the	edicai								
Вох	death certifi attending I for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			1	ite of delivery
	that the death cer ed by the attendin detached for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No			Other (specify)			Mo	onth Day Year
P.0	hat thi d by t detach	Phy	9 ☐ Unknown Part II. Other significant conditi	ons contributing to death l	out not resulting in the u	nderlying cause give	on in Part I	23e Did to	hacco use con	tribute to the cause of death?
ds,	signed to det	d by	Takin one oignioon oona.	ene contributing to doday.	sat not rooming in the a	ndonying oddoo give		1 🗆 Y	V	3 ☐ Probably 4 ☐ Unknown
Cor	w requir been si should	lete						24a. Was a	n 24b.	Were autopsy findings available
of Vital Records,	he tay	Completed						autop:	med?	prior to completion of cause of death?
tal	en: T tificat tor, pa	O	25. Was case referred to medica	al .			26. Place of Deat	1 Yes		1 X Yes 2 □ No
Š	ysici is cer direci	ToB	examiner? XXYes 2	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatier	nt 3 DOA Othe		ome 5 Resid		ner (Specify) SCENE
0	ng Ph ter th neral	uc:	27. Manner of Death 1 Natural 5 Pendi	28a. Date of Injury	ury 28b. Time of Injury	f 28c. Injury Work	at (?	28d. Describe h		
Sio	tendil eath. or: A the fu	catle		igation 21170	5 1.000		res 2 Tho	sunj.		ot self
Division	or At after d Direct in by	Certification:	4 Homicide determ		jury - At home, farm, str tc. (Specify)	Vin		City or Tow	n. State) 82	oo Perry Hall Bly
_	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	3 Ce	29a. Certifier 1 ☐ Certifyi	ng Physicien: To the best	parking	10+	e, date and place		o sectal	e MD
	e Hos	edical		Exeminer: On the basis of and manner s	of examination and/or in					
	To th To th comp	Me	29b. Signature and title of certific	er o	A	29c. License	number M E	2	9d. Date signe	Y 13, 2005
)	*2		· Caral	Hallan	nd	0.0	ri E		LUNCAN	
	S.A.		30. Name and address of person	who completed cause of	death (Item 23a) (Type,	Print) 111 P	ENN STREE	ET. BALT	IMORE.	MARYLAND, 21201
	Sta	fo	31. Date filed (Month, Day, Year	32. egist	rar's Signature			,	-,	,
	Registi		FFR 1	7 2005	w B. AD	arti				

			For State Registrar	State of	Marylan		artment of H rtificate of L			jiene		
	9		Decedent's Name (First, Middle, La	ist)					2. Date of Dea	th ZUU	J.	3 Time of Death
	Physici /Medio		Delphia Ma	e Gro	ve				Februa	ry 14 20)05 	2:00P M
	Examin	er	4a. Facility Name (If not institution, gi		ber)		4b. City, Town, or Cumberl	Location of Death		4c. County of		
	Funeral			spital Sex 7	. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birtho	lace (State or Foreign
ь	Director			1□ M 2 XX	87	Yrs.	Months Days	Hours Min.	Oct. 18	, Year) 1917	Mary	land
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	Od. Inside City Limits
	Maryl -f sho	to	MD. Allega	ny	W	estern	port					1 AYes 2 □ No
	h the or 28a e noti	irec	10e. Street and Number				10f. Zip Code		1	Og. Citizen of W		*
	ath wil	raiD	111 Chestnut	st.			2156			United		
920	be filed within 72 hours after death with the Maryland lat Hygjene. Id other than "natural", or tems 23a or 28a-f show event, If a Modical Examition is notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	:es? ∑∕∑ No	'	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 20x1No	spanic Origin? (Spanic Origin) n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		White,	
2-0	72 ho	eted	15. Decedent's E	ducation ade completed)		(Give	dent's Usual Occupa	lunna most of work	ing	16b. Kind of Bus	iness/Ind	dustry
21215-0036	within ene.	Completed	Elementary/Secondary (0-12) unknown	College (1-	4or 5+)	life. I	DO NOT use retired, omemaker)		Housev	work	
d 2	filed Hygid other ent, I	Be Co	17. Father's Name (First, Middle, Las	1)		l		18. Mother's Name	e (First, Middle, I	Maiden Sumame)	
/lar		To B	James Davi	d Links	wiler			Magg	gie	reeves		
, Maryland	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship Thomas Michaels/		on		ng Address (Street a Chestnut					^{Code)} 21562
Baltimore,	Pages 1 and nent of Hestant: If item		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		tate C	emetery, crer	sition (Name of natory or other place em. Garde	^{e)} 02/1)5 6/	20c. Location - C Keyser,	-	wn, State Virginia
Balti	permit. Pages Department of Findortant: If ite any injury or of once.		21. Signature of Funeral Service Lice	Bol			Name and Address 11 Church	- 10		ral Home t, Mary		21562
10 10 June	Pnysician /Medical Examiner	0	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a Due to (c	ch line.	and	er the mode of dying		or respiratory arm	est,		Approximate Interval Between Onset and Death 2 yew25
68760,	icate be executed physician and s the buriat-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (c	or as a conseq	uence of):						
P.O. Box 6	the death certify the attending iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		th 2 Feta nt at time of d	Ideath 3	Ectopic pregnancy Other (specify)	43.63, 6		23d. Date Mont		ory Day Year
	Se oc	þ	Part II. Other significant conditions	contributing to dea	ath but not res	ulting in the u	nderlying cause give	en in Part I.		bacco use contril es 2 □ No :		e cause of death?
I Records,	The ate ha	Completed							24a. Was a autops perform	ned? de	ior to coreath?	psy findings available inpletion of cause of
Vital	Phyaician: Th this certificate ral director, pac	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Death				
of	Phya r this ral dir	7.	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatien	I 3 DOA	4 Nursing Ho		ence 6 Other		"
Ou	ling After une	tion	1 Natural 5 Pending 2 Accident investigation	(Month	, Day Year)	Injury	Work	r? Yes 2 □ No		,,	_	
Division	or Al	Certification:	3 Suicide 6 Could not determined	289. Place	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office		28f. Location (St City or Town	treet and Number n, State)	r or Rura	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C			sis of examina		n occurred at the tim vestigation, in my op					
	To the within 2 To the complet	Me	29b. Signature and title of certifier	201			29c. License		2	9d. Date signed	(Month,	Day, Year)
			I wouser	KSh	MS)	000	55325		Feb 15	,20	505
	2		30. Name and address of person who WONSOCK SH	completed cause	of death (Item 48 Ta		Print) Erra Ce	Frostb	weg M	02532		
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 7	2005 32. Re	gistrar's Signa	iture	book					

Mary Gre 05-01462 RPD Fu Dir permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phys /Me Exar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

e1	Please										
	1- For Unpend Item 2	State of Ma 23a&27 per	aryland/ me G84	Departm 1_3-18- Certific	nent of H	ealth and Death	l Mental Hy	giene Reg. Ne	200	15	0730
	1. Decedent's Name (First, Middle, Las						2. Date of D Month	eath		V	3. Time of Deat
an al	Mary Elizabeth	Gretschel					Februa	ry 2	5, 2	2005	722 P
er	4a. Facility Name (If not institution, give Calvert Memorial]					Location of De			County		
	5. Social Security Number 6. Se		e (In yrs. last b	oirthday) If U	nder 1 Year	If Under 24 H			lver		place (State or Fore
	216-25-0237 1 Usual Residence of Decedent	□M 2XF 15	5	Yrs. Mon	iths Days	Hours Mi	July 1	ay, Year) L 7, 1	1989	Cour	yland
	10a. State 10b. County		10c. City, To	wn or Location						1	0d. Inside City Lin
Director	MD Calvert	County	Hunt:	ingtown	1						1 ☐ Yes 2 🔀
Dir	10e. Street and Number			10f	f. Zip Code					Vhat Cour	ntry?
era	1580 Stone Drive	12. Was Decedent	Ever in II S	13 Was D	20639	sannia Origin?	/Cassity Vac or N		S.A.		an Indian,
by Funeral	1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:		If Yes,	specify Cubai	Specify:	(Specify Yes or N erto Rican, etc.)	0-	Blac	k, White, White	etc.
ted	15. Decedent's Ed (Specify only highest gra-		168	a. Decedent's		ition Juring most of w	and and	16b. K	(ind of Bu	siness/în	dustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+>	Stude	OT use retired))	rorking	Hig	gh Sc	chool	
Be (17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	, Maiden	Sumam	Θ)	
2	John Max Gretsche	el					rine McMa				
	19a. Informant's Name/Relationship (7		19	b. Mailing Add	iress (Street a	nd Number or i	Rural Route Numb	er, City o	or Town,	State, Zip	Code)
	John Max Gretsche 20a. Method of Disposition	l (Father		580 St.o of Disposition	Me Dri	ve. Hur	tingtown	, Ma	ryla	nd 2	0639 wn, State
	1 🛱 Burial 2 ☐ Cremation 3 ☐		cemet	ery, crematory	or other place		ch ^{ate} 3,				
	' 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fuperal Service Licen		riesuri	rection 22 Nam			2005 ee Funera	OII	nton	'alvo	ryland
	Michael W. L	ze.									
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each lir	itis	not enter the			land Blv ac or respiratory a		Owin	lgo,_	Approximate Interval Between Onset and Death
il Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition	a. Myocard Due to (or as b. Due to (or as c.	ne.	e of):					Owin	150,	Approximate Interval Between
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	ı	. 101	partment of Health and Nertificate of Death		iene 9 No 005	07308
Physic		Decedent's Name (First, Middle, Last) Mary Claire Goodnan		2. Date of Deat Month February	Day Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
Funeral Director		Calvert Memorial Hospital 5. Social Security Number JN 6. Sex 1 □ M 2 ▼ F 85 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, NOV 22 19	19 9. Bir 19 Mar	thplace (State or Foreign ountry) yland
aryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or		-		10d. Inside City Limits
ith the Marylar or 28a-f show	Funeral Director	Maryland Calvert St. Leone 10e. Street and Number	10f. Zip Code	1	0g. Citizen of What C	1 Tes 2 No X
death wil ms 23e o	eral D	5840 Bayside Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	20685 3. Was Decedent of Hispanic Origin? (Single Yes, specify Cuban, Mexican, Puerto		United States	erican Indian,
urs after o	by	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ★ No Specify:	o Rican, etc.)	Specify: W	
perillinities in Marylania 412.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f show any Injury or other treumatic event, the Modical Evantrial must be rudified at once.	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of wor . DO NOT use retired)	king	16b. Kind of Business	/Industry
e filed wi	Be Con	12 2 hart 17. Father's Name (First, Middle, Last)	erraker 18. Mother's Nam	ne (First, Middle, M		
al ylal should b and Menta s marked umatic e	ToE		Mary Cath	erine Fallo ral Route Number		Zip Code)
Te, IV		20a Method of Disposition 20b. Place of Dis	Laurelwood Drive McCle		2 20c. Location - City or	Town, State
cattlifications. Pages partment of portent: If it y Injury or c		'4 □ Donation 5 □ Other (Specify) St. John	Vianney Cemetery 21 20	005	rince Frederi	.dk MD 20678
Deparimine Department of the partment	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ra 405 Broomes Ts. Rd. Por	nusch Funer t Republic			
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition at the cause of cause of cause or candition at the cause of ca	enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death Week
/Medical Examiner	L	Due to (or as a consequence of): PNEUMONI	A			1 week
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ate be exemply side and the purial-		Due to (or as a consequence of): d				
death certific he attending p	Physician/Medical		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	livery Day Year
two requires that the speen signed by the should be detach		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tot	bacco use contribute to	o the cause of death?
Tecolus, The law requires te has been sign	Completed by			24a. Was a autops perform	ry prior to med? death?	utopsy findings available completion of cause of
VICAL DE INCIDENTE INCIDEN	o Be C	25. Was case referred to medical examiner? 1 Yes	Other	th (Check only on	(8)	rify)
Attending Physic of the strength of the streng	1-	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time Injury 2 Accident investigation	of 28c. Injury at		ow injury occurred	City)
DIVISION Attended at the Indian party the	Sertification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.				
To the within To the comp	M	29b. Signature and title of certifier	29c. License number	2:	9d. Date signed (Mont	
12		30. Name and address of person who completed cause of death (Item 23a) (Type SCARIA MATHEW MD, POBOX	789 IUSRY	MD	2065) ,
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Register's Signature FEB 1 7 2005 Marie 1	Sparles			

The law requires that the death certificate be executed Records, P.O. Box 68760. the sding phys the s been signed by the should be detached Division of Vital After

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2100 M Ebruar 08019E Hastings /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Mary lang Dorchester ambridg & 6ENEIa1 Hospita If Under 1 Year | Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1₩ M 2□F 80 Yrs. Director Oct. 4,1924 MD 218-20-7003 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?7 is marked other then "neturel", or Items 23e or 28e-f show treumetic event, the Medical Exprinter must be notified at MD Wicomico 1 Yes 2 No Completed by Funeral Director Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7621 Hanton Ave 21801 12. Was Decedent Ever in U.S. Armed Forces? 1★1Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Carpenter Roofing Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental George Edward Hastings Hettie Margaret Jarvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportent: If item 27 Shirley Hill (daughter) 1504 Lilac Dr., Salisbury, Md. 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Riverside Cemetery Feb.19,2005 Berlin, Md. ¹ 4 □ Donation 5 □ Other (Specify) 21. Liture of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home eny in 108 William St., Berlin, Md. 21811 110000 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conse ence of): Examiner Sequentially list conditions, if any least 1, immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ormad2 2 No lipidemia 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 200 1 Inpatient P 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural
2 Accident Injury 5 Pending 1 🗌 Yes 2 🗌 No hours after death. investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person why D.D. NARR 100 Bramble 5+ 32 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryla	•	rtment of F			iene g. Nõ.	05	07310
	Dhuaiai		Decedent's Name (First, Middle, Last)				2. Date of Deat Month		Year	3. Time of Death
	Physici /Medio		JAMES BRYAN HARRI	NGTON				02	Day 15	2005	1:00 PM
	Examin	ner	4a. Facility Name (If not institution, give				r Location of Death			nty of Death	
4		1	1516 MAGNOLIA DRI 5. Social Security Number 6. Se		(act hirthday)	SALISE If Under 1 Year	URY If Under 24 Hrs.	8. Date of Birth	l W	ICOMI	
	Funeral Director			Drug OFF	2 Yrs.	Months Days	Hours Min.	(Month, Day, 12-23-19	Year)	SALIS	place (State or Foreign ntry) BURY, MD.
			Usual Residence of Decedent				1	12 23 23		9220 2 0 3	, III
vian	how		10a. State 10b. County	10c. C	ity, Town or Lo	cation				1	10d. Inside City Limits
e Ma	Ba-f	cto	MD WICOM	ICO S	ALISBUI	RY					1 ☐ Yes 2√ No
vith th	2 20	Pie.	10e. Street and Number			10f. Zip Code		10	•	of What Cour	ntry?
athy	239	ra i	1516 MAGNOLIA DRI	VE 12. Was Decedent Ever in t	10 121		1804		US	ace - Americ	an Indian
Ter de	le li	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Marned	Armed Forces?			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		lack, White,	
DOOL Hours at	10 July 10 Jul	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		□ Yes 2 No	Specify:		Spec	cify: WHI	TE
2 S	inatur.	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	lent's Usual Occup	ation during most of work	vina .	16b. Kind of	Business/In	dustry
this is	.e	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. L	OO NOT use retired	d)	(ing			
7 %	ygier her th		9		MA	ACHINIST	40 Marker de Norre	- (Fina 14:44)		TORY	
	od otl	Be	17. Father's Name (First, Middle, Last)	DINGEON CD				e (First, Middle, M	faiden Sumi	ame)	
hould bloud	and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28a-f show raumatic event, the Medical Examanar must be invitiled at	은	GEORGE WALTER HAR 19a. Informant's Name/Relationship (T)		19h Mailin	a Address /Street	ALMA SMI and Number or Ru		City or Tow	m State Zin	Code)
4 28	Department of Health and Mental Hygiene. Importent: or Iteme 23a or 28a-f show Importent: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event. The Medical Exartains must be indiffied at 00ce.		ELAINE HARRINGTON				DRIVE, S.		•		
, <u>,</u>	t Hea item other	1.8	20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place				n - City or To	
CHILITHON	nt: If	Ш	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	temoval from State	-		CEM: 02-	19-2005	SHARPT	OWN, I	MARYLAND
	Departm Importe any inju		21. Signature of Funeral Service Licens	98	22	. Name and Addre	ss of Facility BO	UNDS FUNI	ERAL H	IOME.	INC.
Ď Š	8 2 3	0.0	Jenes &	Kelly			AIN STRE				
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the dea ne cause on each line.	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between
PI	hysician		Immediate Cause (Final disease or condition	CONG	EST.	VE ItE.	ART F	AILUP 3			Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a conse	quence of):						
		je.	Sequentially list conditions,	Due to (or as a conse	A 2-7	APTE.	LY DI	38A88			
ted	Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		, , , , , , , , , , , , , , , , , , , ,						
), exect	in and	Exa	that initiated events resulting in death) Last	Due to (or as a conse	quence of):						
Do ye	ohysician and the buriat-transit	dicai		d							
rificat	ng ph as t	Med	IF FEMALE:								
ath cer	attending p	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3 [Ectopic pregnancy				Date of delive	ary Day Year
. §	the all	Physician/Me	1 Yes 2 No	4☐ Pregnant at time of 9☐ Unknown	death 5□	Other (specify)			10	nontin	Day
I RECOLDS, P.O. DOX 08/00, The law requires that the death certificate be executed	been signed by the should be detached		Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	ideriving cause giv	en in Part I.	23e. Did tob	acco use co	ntribute to th	ne cause of death?
ecords, law requires t	n sign	d by			•	, ,		T	s 2 No		ably 4 Unknown
S S S	beer	Completed						24a. Was an	246	. Were auto	osy findings available
n el	is certificate has director, page 2	dmo						autopsy perform	ed?	death?	psy findings available mpletion of cause of
VII de licion:	tifical for, p	Be C	25. Was case referred to medical		-		26. Place of Dear	1 Yes 2 th (Check only one	E No	1 🗆 Yes	2 NO
ÇO.	this cer al direc	To B	examiner? 1 ☐ Yes 2X☐ No	Hospital: 1 Inpatient 2] ER/Outpatien	t 3 DOA Oth	er: 4 🗌 Nursing Ho	ome X Reside	nce 6 🗆 O	ther (Specify	y)
e o	fter th		27. Manner of Death 1X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor		28d. Describe ho	w injury occi	urred	
OIVISION or Attending	eath. or: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □No				
JIVI or At	Direct Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, stre ify)	et, factory, office		28f. Location (Str City or Town,	eet and Nun State)	nber or Rura	I Route Number,
T lejida	ours a		29a. Certifier Certifying Phy	sician: To the best of my kn	owledge death	occurred at the tin	ne date and place	and due to the ca	uso(s) and s	nannar ac et	
DIVISION OF VICE To the Hospitel or Attending Physician:	• Fur	edicai		ner: On the basis of examin and manner stated.	ation and/or inv	estigation, in my o	pinion, death occur	red at the time, da	te and place	e, and due to	the cause(s)
To th	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral of	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date sign	ned (Month,	Day, Year)
	100		folgalla	- M.D.			D29168	j.	-118	105	
(200		30. Name and address of person who co	· · · · · · · · · · · · · · · · · · ·		•			3.5		
`	, () <u>,</u>		ROBERT ALLEN, M.D			TREET, SA	LISBURY,	MARYLANI	2180)4	
	Sta Registr		31. Date filed (Month, Day, Year) 8 21	32. Registrar's Sign	J. A	nauli					

			For Stete Registrer	State of Mary		artment of H			iene _{g. No} 2005	07311
	Dhusisi		1. Decedent's Name (First, Middle,	Last)				2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medio		Evelyn M. Har	rell				Februar		
	Examin	er	4a. Facility Name (If not institution,				Location of Death		4c. County of Dea	
			Prince Georges H 5. Social Security Number 6		yrs. last birthday)	Chever	Cly If Under 24 Hrs.	R Data of Birth	Prince (
	Funeral Director		230–40–3466	1□M 2⊠F 100	Ven	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 23,		thplace (State or Foreign ountry) eqon
lu.	pu 🖈		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Le				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	172 hours after death with the Maryland "natural", or items 23a or 28e-1 show idical Exertifier must be rivilided at	ō			<i>l</i> ashingto					10d. Inside City Limits 1 □XYes 2 □ No
	r 28e-	Director	D . C . 10e. Street and Number			10f. Zip Code		10	0g. Citizen of What C	ountry?
	h with		4840 McArthur Bl	vd. N.W. B1-c	8	200	07		United Sta	ates
	deat	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
98	or ite		1 Never Married 2 Marrie	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2√∑ No		riioari, etc.)	Black, Whi Specify: W	
00	hours tural',	ed by	3√ Widowed 4 Divorced 15. Decedent's	Year or Dates:		dent's Usual Occup		1		
15	C 2	plet	(Specify only highest	grade completed)	(Give	kind of work done of DO NOT use retired	during most of work	ing	16b. Kind of Business	Vindustry
21215-0036	d within giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Hon	maker			Own Hor	ne
pu	be filed within tal Hygiene. Ind other than svent, the M	Be	17. Father's Name (First, Middle, La				18. Mother's Nam		Maiden Surname)	
Maryland	should be nd Mental marked o	²	John Walter Mc 19a. Informant's Name/Relationship	Cormmach	105 14-16	4 (01	Laura		City or Town, State,	-
Ma	s 1 and 2 should Health and Meritem 27 is marke other treumatic		Linda Harrell/	,						D.C. 2000
re,	is 1 and 2 of Health a item 27 Is other tree		20a. Method of Disposition	2	Oh Place of Disno	osition /Name of		Date /	20c. Location - City or	
Ë			1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State Cify)	eo. Wash Tedical C	matory or other place. Univers	Sity Febr 20	uary 17	Washingtor	D C
Baltimore,	permit. Page Department of Importent: If any injury or orige.		21. Signature of Dineral Service Lie		2:	2. Name and Addres	ss of FacilityCol	umbia Mo	rtuary Ser	vices, Inc.
-	40E 5 0		C5 WHZ	Serch	1	Ρ.	.O. Box 5	8007 <i>⊡</i> Wa	shington,	D.C. 20037
Ü			23a. Part1. Enter the disease, or co shock, or heart failure. List or	inplications that caused the ly one cause on each line.	death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Sep	sis S	morbay				Onset and Death
	/Medical Examiner		rosularing art dodarry							1
		ë	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):	ne				1
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	be executed sician and burial-transit		resulting in death) Last	cDue to (or as a co	nsequence of):					
8760	ate hys	Physician/Medical	,	d						
9	eath certific attending p	/Mec	IF FEMALE:	23c. If yes, outcome of pr	regnancy					
Вох	atten for us	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death 3[Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
Ö	at the de by the a tached	hysi	1 U Yes 2 No 9 Unknown	9□ Unknown						
S, D	requires that the een signed by th hould be detache	by P	Part II. Other significent condition:	s contributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord	w require been si should b		Advance	Age	7			1 ☐ Ye	s 2 2 0 3 □ Pi	robably 4 Unknown
of Vital Records,	aw as b	Completed	Decorp	roted (stepper	no He	at tail	24a. Was ar autopsy	prior to	utopsy findings available completion of cause of
alF					<i></i>			perform 1 Yes 2	ned? death? YNo 1 ☐ Yes	2 × 100
V.	Physicien: this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	0 El EB (0)	Othe	26. Place of Death			
			27. Manner of Death	Hospital: 1 Appatient 28a. Date of Injury	2 ER/Outpatier 28b. Time o	f 28c. Injury	/ at	me 5 Hesidei 28d. Describe ho	nce 6 Other (Spe w injury occurred	cify)
ion	Attending I r death. sctor: After by the funer	atlo	1 Accident 5 Pending investigat	(Month, Day Yea	a <i>r)</i> Injury	M 1 🗆 '	Yes 2 No			
Division	or Attendater deati	ertification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	28e. Place of Injury - building, etc. (S	At home, farm, str	reet, factory, office		28f. Location (Str City or Town,	eet and Number or Re State)	ural Route Number,
	Hospitel or 24 hours afte Funeral Dir tely filled in b	0	<u> </u>	<u>d</u>						
	To the Hospitel or Atto within 24 hours after de To the Funeral Directo completely filled in by the	edical	29a. Certifier 1 Certifying (Check only 2 Medicel Ex	Physicien: To the best of my eminer: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the time vestigation, in my op-	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 0		29c. License	number	, 29	d. Date signed (Mont	h, Day, Year)
	20		> K. Men.	heet free	-	700	52865		Coloner	16 2005
	20		30. Name and address of person wh	o completed cause of death		Print)				
			31. Date filed (Month, Day, Year)	+ELFIGARE		3001 Hos,	0,7742 D.	e, CHEUR	ery, Mo ;	20785
	Sta Registr		FEB 1 8 2005	32. Registrar's S	-igitature				,	

			_ For	State of Maryland /	Depa	artment of H	lealth and M	-		
			1 - State Registrar		Cer	tificate of	Death	F	Reg. No UU	5 073/2
ı,	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Yea	3. Time of Death
-	/Medic		CHARLES FREDR					Februa		005 12:30 A M
	Examin	er	4a. Facility Name (If not institution, give s				or Location of Death		4c. County of D	
1			303 Rivermont Dr			Waldor		a Day of Birth	Charle	
100	Funeral Director		376-30-3033	M 2□F 7. Age (In yrs. last b.	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 5,		Birthplace (State or Foreign Country) rginia
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Lo	cation				10d. Inside City Limits
	f ehd	ō	Maryland Charles	Ma	1dor	of.				1 □ Yes 2 □ No
	28a	Director	10e. Street and Number	wa	Tuoi	10f. Zip Code			10g. Citizen of What	Country?
	3a ou	0	303 Rivermont Driv	٩			20602		USA	
	death ms 2	Jera		2. Was Decedent Ever in U.S.	13. \	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		merican Indian,
9	or Ita	by Funeral	1 ☐ Never Married 2 🏹 Married	Armed Forces? 1 XYes 2 □ No If Yes, Give		i res, specify Cub 1 □ Yes 2 🏿 No		rican, etc.)		White
93	ours Feb.	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			эрөспу.		Specify:	WILLE
ν.	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a completed)	a. Deced (Give	lent's Usual Occup kind of work done	pation during most of work d)	ing	16b. Kind of Busine	ss/industry
12	han within	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)		ce Offic			Coount (Comuias
7	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ehow int, the Madical Examinar must be molified at	ပိ	17. Father's Name (First, Middle, Last)		PULL	ce offic	18. Mother's Name	e (First, Middle,	Secret S	service
an	d be sortal	To Be	Charles Hohenstein						usta Kehl	
Maryland 21215-0036	should and Men marke umatic	-	19a. Informant's Name/Relationship (Typ		b. Mailin	g Address (Street			r, City or Town, State	a, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show appriants of the traumatic event, the Maulical Examination and Dance.		Akemi D. Hohenstei	n - Wife	303	Rivermo	nt Drive,	Waldor	f, MD 2060	02
Baltimore,	ss 1 a of Hei Item		20a. Method of Disposition	20b. Place cemet		sition (Name of natory or other pla		-	20c. Location - City	
Ē	Pages nent of i		1 X Burial 2 □ Cremation 3 □ Re 14 □ Donation 5 □ Other (Specify)				Gdns 2-18	-05 N	Waldorf, N	MD
ati	permit. Departn Importa any inju		21. Signature of Funeral Service License	● M01391	22 LJ	. Name and Addre	ess of Facility	1		
<u> </u>	8258	1 1	Ith Hyde			. U. DUX		dorf, MD	20604	
18			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death. Do	not ente	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	HEYA	16	1 NV F	+			W V V V
震	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):	0.00.0			-=-	L: 10 a a .)
E		_	Sequentially list conditions, b	Due to (or as a consequence	147	15/1/2	ζ,		1	V (100 00)
	pet usit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Q A A A	o OI).	Vaso	1 Calmo	Di su-	<u> </u>	+ wrong)
	arecu al-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	e of):					- N
760	eath certificate be executed attending physician and for use as the burial-transit	calE	L _d	Lung ?	74	cure				x Mm)
89	ificat g phy as the								1	
Вох	h cert endin	N/CI	23b. was decedent pregnant	3c. If yes, outcome of pregimicy 1□Live birth 2□Fetal deat	h 3	Ectopic pregnanc	v.		23d. Date of	*
m	deat	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death		Other (specify)	,		Month	Day Year
P.0.	that the de led by the a detached f	Physiclan/Medl	9 Unknown					T an Didus		
s,	80 00	by	Part II. Other significant conditions con	induting to death but not resulting	in the ur	nderlying cause giv	en in Part I.	in the state of th		e to the cause of death? Probably 4 □Unknown
0.0	w require been si should l	eted								Probably 4 Donkhown
Division of Vital Records,	has b	Completed						24a. Was a autops perform	y prior t	autopsy findings available to completion of cause of
a T	r: Th							1 ☐ Yes	2 No 1 Y	es 2 No
Ž	Attending Physician: sr death. ector: After this certification in the funeral director.	Be c	25. Was case referred to medical examiner?	ospital:	-	. 2C PO. Ott	26. Place of Death			
of	Phys r this iral di	.: To	1 Yes 27 No	28a. Date of Injury 28b.	utpatien Time of	1 3 DOA	4 Nursing Ho		ence 6 Other (S)	pecify)
lon	th. : Afte	it lor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2 □ No			
Vis	Atter er dea ector by the	iffica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (Si City or Town	treet and Number or	Rural Route Number,
	tal or A	Certification:	Tomos	building, etc. (apecity)					1, Olato)	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical Examin	ician: To the best of my knowledger: On the basis of examination a	ge, death ind/or inv	occurred at the til	me, date and place, ppinion, death occurr	and due to the c	ause(s) and manner ate and place, and d	as stated. lue to the cause(s)
	the the mplet	Med	29b. Signature, and title of certifier	and manner stated.		29c. Licens	e number	1 2	9d. Date signed (Mo	onth Davil Year)
	5 ± <u>¥</u> 5 8		and the of control	1/1-100	n	1	DONG	70	bli	1/07
0			30. Name and address of person who con	moleted cause of death (Item 22s)) (Type	Print	000	0 -	2/1	2/01
1	\$ 531			then, 11345 Pemb			LO3, Waldo	orf. MD	20603	
170	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		4		,		
	Registr	ar	FFB 1 7 20	105 Magree 1	6 4	beele				

		For State Registrar		State	of Maryla	and / Depa		t of H	ealth a			giene Reg. No.	200	5 (73	13
Physicia /Medica		1. Decedent's Name (F Malinda									2. Date of De Feb. 18 2		Yea		Time of Do	eath M
Examine		4a. Fecility Name (If no Solomons Nu			umber)			Town, or	Location o	f Death			County of De			
Funeral Director		5. Social Security Num 219 72 4300		6. Sex 1 ☐ M 2 ☐ F	7. Age (In ye	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da Feb 13 1	th y, Year) 956	9. E Wa	Birthplace (Country) shingt	State or F	oreign
Maryland f show	ŏ		ob. County Calvert		10c.	City, Town or Lo	ocation								side City	
with the 3a or 28e-	i Director	10e, Street and Number 11444 Rawhii	de Road	a a			10f. Zip	Code 20657	7				en of What ted Sta			
S sil	by Funerai	11. Marital Status 1 Never Married 3 Widowed 4	_	Armed F	2.⊠No ive		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		4. Race - Ar Bleck, Wi			
d within 72 hd giene. rr than "netu	Completed	15 (Specify Elementary/Seconda		t grade completed	(1-4or 5+)	16a. Dece (Give life. cafete	dent's Usua kind of woi DO NOT us Pria	il Occupa rk done d se retired,	ation during most)	of worki	ing		ic Scho			
yldilo buld be file Mental Hy arked oth atic event	To Be (17. Father's Name (Fire Robert Mallia	ar 						Margu	erite	e (First, Middle, e Selman					
and 2 sho and 2 sho ealth and m 27 ie m		19a. Informant's Name Hoard Fdward	Hancoo		lasi	11444	Rawhio	e Rd.	. LUSby	, MD						
Deficiency of the page of the		20a. Method of Dispos 1 ☐ Burial 2X C 1 ☐ Donation 5	Cremation			Place of Dispo cemetery, createry				22 20	005		ation - City ndria V			
Physician /Medical Examiner pontion and pontion and pontion in price of pontion in price of p	edicai Examiner	23a. Part1. Enter the candidate Cause (Findisease or condition resulting in death) Sequentially list condition and the cause. Enter Underlyi Cause (Disease or injuthat initiated events resulting in death) Las	disease, or of aillure. List of all tions, or distend	complications that only one cause on Due to b.	each line.	eeth. Do not en	er the mod	mes I e of dying	s m g, such as	Rau Pont cardiac o		C MD :		Inter	oximate val Betwe at and De.	ath
To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pr in the past 12 rpc 1 □ Yes 2 ☑ N 9 □ Unknown	nths?	1 Live	utcome of pre- birth 2 F gnant at time on nown	etal death 3	∃Ectopic pr ∃ Other <i>(sp</i>					2	3d. Date of o	delivery Day	Yea	ar
w requires that should be detailed to should be detailed to the should	þ	Part II. Other significa	nt condition	ns contributing to	death but not	resulting in the u	nderlying c	ause give	en in Part I.				se contribute			
The law re rate has bee page 2 sho	Completed										24a. Was autor perfo 1 - Yes		24b. Were prior t death 1 🗌 Y	o completion?	on of cau	ariable se of
Physicien: Thysicien: This certificate and director, p	To Be	25. Was case referred examiner? 1 ☐ Yes 2 ☑ No				ER/Outpatie		-	er: 4 ⊉ rÑu	rsing Ho	n <i>(Check only d</i> me 5 ☐ Resid	dence 6		pecify)		
Attending P art death. ector: After the funera	Certification:	2 Accident 3 Suicide	5 Pending investig 6 Could n	ation ot be	of Injury nth, Day Year, se of Injury - A	28b. Time o Injury	М		rat k? Yes 2 □ I	No	28d. Describe f	Street and		Rural Roul	te Numbe	or,
spitel or nours after nerel Direct Hilled in E		4 ☐ Homicide 29a. Certifier 1[Certifying	g Physician: To ti	ding, etc. (Spe	knowledge, deat	h occurred	at the tim	ne, date an	d place,	City or Tov	cause(s)	and manner	as stated.		
To the Ho within 24 h To the Fu completely	Medical	(Check only 2 one) 29b. Signature and title	☐ Medical B	examiner: On the	basis of exam	ination and/or in	vestigation,	in my op	oinion, deal	th occurr	red at the time,	date and 29d. Date	signed (Mo	onth, Dey,	Year)	
10		30. Name and address	of person v	who completed ca	use of death (I	tem 23a) (Type,		10	30 A	7 S	U/63/	0 A	18/0	podenie	-k (m
Stat Registra		31. Date filed (Month,		1 8 2005	Registrar's Si	gnature	Spa	all of	V					- C. C.		/

DS DAM	1 - State Registrar			Certifica	ate of	Death	R	ag. No.	JUJ	0/31
sician	1. Decedent's Name (First, Middle	e, Last)					2. Date of Deat Month	th Day	Year	3. Time of Death
dical	Margaret Ca 4a. Facility Name (If not institution		ckman	4b Cit	h. Tourn a	or Location of Death	Februar	y 14, 2	-	2:20 A
ner	Anne Arundel Med	-			Annap				Arun	ndel
Г	5. Social Security Number		e (In yrs. last bii	rthday) If Und	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreigntry)
	021-01-2688 Usual Residence of Decedent	8.	5	Yrs.			1-4-192			achusetts
	10a. State 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Limit
ctor	Maryland Anne A	Arundel	Anı	napolis						1 □ Yes 2 🔀 N
Funeral Director	10e. Street and Number	om Corro			Zip Code		1	0g. Citizen of 1		ntry?
erai	2634 Quiet Wate	12. Was Decedent	Ever in U.S.		1401	Hispanic Origin? (Spe	ecify Yes or No-	US.	A Americ	an Indian,
	1 Never Married 2 Marr	Armed Forces? 1 XYes 2 1 If Yes, Give			pecify Cubi	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)		ck, White,	
	3 XWidowed 4 □ Divorced	Year or Dates:						Specify		ite
iete		st grade completed)		. Decedent's Us (Give kind of y life. DO NOT	sual Occup <i>work done</i> Tus <i>e retire</i> i	pation during most of worki d)	ing	16b. Kind of B	usiness/Ind	dustry
Completed	Elementary/Secondary (0-12)	College (1-4ors	5+)	Registe				Hea.	lth C	are
Bec	17. Father's Name (First, Middle,					18. Mother's Name			ne)	
70	James E. Meeg						V. Spell			
	19a. Informant's Name/Relations					and Number or Rura				
	Edward C. Hickn 20a. Method of Disposition		20b. Place o	f Disposition (A	vame of	rg Dr., Da		111E [
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from State pecify)		ry, crematory`o. Cerans (ery 2-17-	-05	Crowns	ville	. MD
	21. Signature of Funeral Service	Licensee				ess of Facility Geo				
	100mlowa			2973	Solo	mons Islar	nd Rd. E	idgewate		D 21037
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death. Do ne.	not enter the m	ode of dyir	ng, such as cardiac d	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	- a prive	mon	a.						
			a consequence	or):						
ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):						· · · · · · · · · · · · · · · · · · ·
kaminer	Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence	of):					-	
ai Ex	, ,	Due to (or as	a consequence	or).						
edic		d								
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	ı 3⊡Ectopic	pregnanc	v			te of delive	
sici	in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at		5 Other (Мо	nth	Day Year
Phy	Part II. Other significant condition	ons contributing to death b	ut not resulting i	n the underlying	g cause giv	ven in Part I.	23e. Did tob	pacco use cont	ribute to th	ne cause of death?
d by							1 ☐ Ye	s 2 No	3 Prob	ably 4 🗆 Unknow
ompieted							24a. Was a		Were autor	psy findings availabl
Com							autops perform	ned?/	death? 1 □ Yes	npletion of cause of 2□ No
Be (25. Was case referred to medical examiner?	Heavital:			011	26. Place of Death	(Check only on	θ)		
-T	1 Yes 2 No	Hospital: 1 2 Inpatie		utpatient 3 1	DOA Oth	4 Nursing Ho	me 5 Reside			<i>ı</i>)
6	1 Natural 5 Pendin 2 Accident investig	g (Month, Da		Injury M	Wor	rk?` Yes 2 □No	200. 2000. 20 110	w inquity coodin		
표	3 Suicide 6 Could	ined 288. Place of In	ury - At home, fa c. (Specify)	arm, street, facto	ory, office		28f. Location (St. City or Town		er or Rura	l Route Number,
tificati										
Certification:		a Physician: To the best	of my knowledge	e, death occurrend/or investigation	ed at the tir	me, date and place, a opinion, death occurr	and due to the ca ed at the time, da	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)
	(Check only 2 Medical	Examiner: On the basis of	ated	•						
Medical Certificati	29a. Certifier to Certifyin (Check only one) 2 Medical 29b. Signature an ∫title of certifie	Examiner: On the basis o and manner st	ated.		29c. Licens	se number	25	9d. Date signe	d (Month, L	Day, Year)
	(Check only 2 Medical one)	Examiner: On the basis o and manner st	ated.			se number 58510	29	9d. Date signed	/	

State of Maryland / Department of Health and Mental Hygiene | For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Feb. 25, 2005 **Physician** Charles Milton Hilgartner 1:45 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore HCR.Manor Care-Towson Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year | July 29, I 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F 92 216-01-6972 Director Yrs Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or items 23e or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Monkton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maplehurst Lane 21111 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. I □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ne any injury or other treumatic event, II a Mind. 2008. Elementary/Secondary (0-12) College (1-4or 5+) Construction Equipment Diesel Technician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Louis J. Hilgartner Johanna Lins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Hilgartner/Son 715 Maplehurst Lane, Monkton, MD 21111 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Slate 20a. Method of Disposition Dulaney Valley March 1, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD 21093 ' 4 □Donation 5 □Other (Specify) 2005 Memorial Gardeńs 22. Name and Address of Facility
J. J. Hartenst
24 Second St. 21. Signature of Juneral Service Licens . Hartenstein Mortuary, Second St., New Freedom, 17349 Approximate Interval Between Onset and Death Party Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediale Cause Final disease or condition resulting in death) **Physician** ON6EST /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 1 Yes 2 No or Attending Physicien: To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospilal: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 1 Inpatient 2 ER/OutpatienI 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury al Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide VCCrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mus who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Regisfrar's Signature State Registrar 2005

			1 = For State Registrar	State of Ma	ryland	-	artment of H				giene	CUU.	07316
	Physicia	an	1. Decedent's Name (First, Middle, Las)						2. Date of De.	ath Day	Year	3. Time of Death
	/Medic	al	Evelyn Hovanec 4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location	of Death	teb	4c.	County of Deal	
	Examin	er	Moviner Hea	HM-B	Adi		BELA	5			H	as for	id
ī	Funeral		5. Social Security Number 6. Se		(In yrs. las 85	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8	8. Date of Birt Month, Pa 1/25/2	th V Year)	9. Birn Co	thplace (State or Foreign buntry) V YORK
ŀ.	Director		132-01-3611 Usual Residence of Decedent		<u> </u>					1/23/2	.0	Nev	V YORK
	death with the Maryland ms 23e or 28a-f show rmust be notified at	_	10a. State 10b. County	į.		Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the Mi	Director	MD Harfor	J.		T ATI	10f. Zip Code				10a. Citi	zen of What Co	
	d within 72 hours after death with the Marylar jiene. Jiene. r then "neturel", or Items 23e or 28e-f show the Medical Examiner must be notified at		1224 Marston Ct.				2101	5			-	U.S.A.	
	tems ?	Funeral	11. Marital Status	12. Was Decedent E- Armed Forces?		13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Ori n, Mexicar	igin? (Spec n, Puerto R	ify Yes or No ican, etc.))-	14. Race - Ame Black, Whit	
350	hours after turel', or ite al Examine	by Fi	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	0		1□Yes 2⊠No	Specify:				Specify: Wh	nite
2-003p	72 hou	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)		(Give	dent's Usual Occupa	durina mos	at of working	g	16b. Ki	nd of Business	/Industry
7	within 72 ene. then "nei	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)		oo NOT use retired ery Clerk)			F	rintin	ד
מ	Hyg Hyg sthe	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>	1	DIIIC	Ly CICIA			(First, Middle,	Maiden		
yland	should be nd Mental smarked c	ToE	Edward Fajans							Meerss			
Ma	O 00 00		19a. Informant's Name/Relationship (7 Jeanne Rosser (D				ng Address (Street a					r Town, State, 2 015	Zip Code)
ē,	s 1 and 3 Health item 27 other tr		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of natory or other place	e)	Da	ite	20c. Lo	cation - City or	Town, State
Baitimore,	ment clear; If		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		A. Fei	cris & Co	•	3/1/0			: Cheste	er, PA
Ball	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licen	Belln	ran	22	Tarring Aberdeen	čárgo , Mar	ylanc	ral Ho 2100	ome, 01-33	P.A. 399	
	Physician		3a. Part1. Enter the disease, or compositions of the state of the stat	lications that caused to ne cause on each line	the death.	Do not ent	er the mode of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a	conseque		عصدنام						241
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	conseque		real IA	(and	_				cur,
1	cuted nd ransit	Examiner	that initiated events	. Itabel	N CO	لتلالع	thy						year)
9	death certificate be executed e attending physician and of for use as the burial-transit		resulting in death) Last	Due to (or as a	conseque	nce of);							
789	ificate g physi as the	edical	•	d									
X O R	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			Ectopic pregnancy				4	23d. Date of de	. ,
Э. П	at the dea by the at: stached fo	ysici	in the past 12 months? 1 ☐ Yes No 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	ime of dea	th 5	Other (specify)					MOIII	Day Year
1	The law requires that the ste has been signed by the bage 2 should be detache	by Ph	Part II. Other significant conditions of			-		en in Part l	1.	23e. Did t	obacco u	se contribute to	the cause of death?
Srds	w require been sig should b	ted t	A 12 hours dan	extin bu	llow	pen	phigad			101	Yes 2	No 3□P	robably 4 Unknown
Hecords,	a law r has be e 2 sh	Completed	Leperlipidemi			•				24a. Was		24b. Were au prior to death?	utopsy findings available completion of cause of
		e Col	25. Was case referred to medical					OF Place	of Dooth	1 ☐ Yes	2 0 No	1 🗆 Yes	₩ No
Vita	Physicien: r this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatien	nt 2 🗆 EF	P/Outpatier	nt 3 DOA Othe	0.00				6 □Other (Spe	city)
n of	ng fter		27. Manner of Death 128 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury	Worl			3d. Describe I	how injur	y occurred	
Division	death.death.ctor: A	licat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injur	rv - At hom	ie, farm, str		Yes 2□		Bf. Location (S	Street an	d Number or Ri	ural Route Number,
2	s after s after bl Dire	Certification;	4 Homicide	building, etc.	(Specify)					City or Tov	wn, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best of iner: On the basis of and manner stat	examinatio	edge, death n and/or in	h occurred at the tin vestigation, in my o	ne, date ar pinion, dea	nd place, ar ath occurred	nd due to the d at the time,	cause(s) date and	and manner as I place, and due	s stated. a to the cause(s)
	To the within To the Comp	Σ	29b. Signature and title of certifier	m			29c. License	1 C. 7	7 7	.	7	e signed (Mont	
			30. Name and address of person who	completed cause of de	ath (Item 3	(Type	Print)		27		4	(2.7t.	
	4		PATRICIA DUBY	JIKI W	ل ك ك	en-l M	racphal K	16	elA.	> M	21:	514	
1	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 4 20	05 32. Agistra	r's Signatu	re ·	Print) Nachwy K						

State Registrar completed cause of deat Item 23a) (Type, Print) M.D

32. Pagistrar's Signature

conber

2005

31. Date filed (Month, Day, Year)

OCME

111 Penn Street

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician AM Melvin Thomas Hagenstad February 13, 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 680 Americana Drive, Apt. 43 Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 5, 1938 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**⊠**M 2□F 67 477-42-0878 Yrs Illinois Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show treumatic event, the Madical Examiner must be notified at Maryland Anne Arundel 1 ☐ Yes 2X No Sherwood Forest Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Glen 1 21405 238 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes ŽQXNo Specify Be Completed by 3 Widowed 4 Divorced 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e kind of work done du DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civil Service U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fil tment of Health and Mental H tant: if item 27 is marked oth jury or other treumatic even Milton Hagenstad Helen M. Morrissev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Hagenstad/wife 930 Acoma, #420 Denver, Colorado 80204 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 © Cremation 3 □ Removal from State permit, Page Department of Important: If any injury or once. * 4 □ Donation 5 □ Other (Specify) Metro Crematory 2/14/2005 Baltimore, Maryland 21. Signature of Fineral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sudden Death Physician /Medical Due to (or as a consequence of): Examiner Coronary Bypass Surgery Sequentially list conditions, if any, leading to immediate saus. Enter the control of Cause (Disease or injury that initiated events resulting in death) Last 8 years Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Coronary Artery Disease 8 years and Due to (or as a consequence of): Box 68760, Hypertension 30 years Completed by Physician/Medical igned by the attending p be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Records, P. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1XX Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2X No Division of Vital To the Hospitel or Attending Physicien: Friend's 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 Residence 6 Nother (Specify) residence 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death 2 Accident after death Director: the 3 🗀 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide within 24 hours a To the Funerel L TV Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier D08314 February 14, 2005 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) George C. Samaras, MD 116 Defense Highway Annapolis, Maryland 21401 31. Date filed (Month, Day, Year) 32. Pristrar's Signature FEB 1 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** BETTY LOU JOHNSON 2005 0420 15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F Hours Yrs. WV 61 11/16/1943 Director 220-40-5952 Usual Residence of Deceden within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f show the Modical Examiner must be notified at 1 Yes 2 No **Funeral Director** Worcester Ocean Pines MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21811 11427 Manklin Creek RD #6 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married White Specify: Completed by 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lounge Manager Airlines es 1 and 2 should be filed vol Health and Mental Hygie fitem 27 is marked other trother traumatic event, ID. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harold T. Dickenson Margaret Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) and 2
went of Health ar.
int: if item 27 is m Harold T. Dickenson 1505 Addie Lane Culpeper, VA 22701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/16/05 Pages nent of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Frankford, DE 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crematory 22. Name and Address of Farthe Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St. Berlin, MD 23. Part1. Enter the clisease, or complications the shock, or hear folium. List on the cause of Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) sensis **Physician** /Medical Due to (or s a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsate or init) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Completed by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the atte Day Year Month 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 DNo 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ 1√0 1 Yes 2ENo 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ļ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral of 28b. Time of 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending 1 Matural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 T Homicide within 24 hours a To the Funerel C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Mame and address of person who completed cause of death (Item 23a) (Type, Print) (4 31. Date filed (Month, Day, Year) FEB 1 6 2005 egistrar's Signature State

Registrar

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O.

		•	For State Registrar	State of M	aryland /		rtment of H tificate of I	ealth and N Death		ege 0 0 5	07320
			1. Decedent's Name (First, Middle,	Last)					2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		LAWRENCE	S.	JENSE	π			Feb 1		10:00Å
	Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Death	1	4c. County of Dea	th
			Holy Cross	Nursing &	Rehab	o	Burto	nsville	е	Montgo	mery
-	Funeral			6. Sex 7. Ag	ge (In yrs. last	birthday)	If Under 1 Year Months Days			Year) 9. Birt	thplace (State or Foreign
	Director	1	214-18-2687	1 M 2 F	84	Yrs.	Wortens Buys	110010	Mar 13	,1920 Mar	
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	show	_	10a. State 10b. County								MXYes 2 □ No
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	or 2	Director	10e. Street and Number				10f. Zip Code		11	og. Citizen of What Co U . S . A	•
	filed within 72 hours after death with the Maryland Hygiene. sther than "naturel", or Items 23a or 28a-f show ant, Ite Medical Examiner must be nutified at		3461 Daisy			40.11	21797		- '/ W - N	14. Race - Ame	
	tems	Funerai	11. Marital Status	12. Was Decedent Armed Forces	?	13. W	ras Decedent of H Yes, specify Cuba	ispanic Origin? (Si n, Mexican, Puert	o Rican, etc.)	Black, Whit	
36	s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	ed 1 XYes 2 If Yes, Give Year or Dates:	OT 7.7	1	□ Yes 2 No	Specify:		Specify: B1	ack
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0	be filed within 72 hours after death with the Marylan ital Hygiene. or items 23e or 28e-f show other than "naturel", or items 23e or 28e-f show svent, ite Modical Expriner must be notified at	O I	17. Father's Name (First, Middle, L	_ast)				18. Mother's Nam	ne (First, Middle, M		
Maryland 2121	permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic sve	To B	Herman	Jensen			1	Fra	nces H	olland	
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Σ	and Salth		Leona Jensen-	Daughter				Road Wo	- quality	MD 2179	
Baltimore,	T T T T		20a. Method of Disposition	3 □Removal from State	rem	e of Dispos etery, crem	ition (Name of atory or other plac	e)		20c. Location - City or	
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			29a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cause	d the death.	De not ente	r the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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	/Medical		resulting in death)	a	a consequen						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Jolley Kevin eb 2005 avon /Medical 4a. Facility Name (If not institution, give street and number) 4b. Oity, Town, or Location of Death 4c. County of Death Examiner Cambridge
If Under 1 Year If Under 24 Hrs. 48. D Dorchester General Dorchester Hospital 7. Age (In yrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 36X 102 M 2□ F Days 214-80-7528 Usual Residence of Decedent Yrs. Director Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location other traumatic event. The Medical Examiner must be notified at 1 To Yes 2 □ No To Be Completed by Funeral Director orchester Vienna 10f. Zip Code 10g. Citizen of What Country? St. 107-Middle CP.O.BOX 435 12. Was Decedent Ever in U.S. Armed Forces?

1 1/2 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 6 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Black 1986 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 le marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Auto-Detailing Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Banks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) YRONE 19a. Informan's Name/Relationship (Type, Print) 104 Middle Street-Vienna Maryland 21869

Date 200. Location - City or Town, State If item 27 Jacqueline Jolley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Purial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Bucktown Cemetery! 2/17/05 * 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD. 22. Name and Address of acility
HENRY Funeral Home, 22. Name and Address of Facility

Henry Fune Rol Home, P. A.

Henry Fune Rol Home, P. A.

510 Washington St. Cambridge, MD, 21613

23a. Part Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final Acquired **Physician** innunc deficiency Syndrone disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Carivil neunocishi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Precenouits Lodiation that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death
4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 164 mall cell concer 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 2 No 2 🗖 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records. after death. filled in by within 24 hours a To the Funerel D

> 31. Date filed (Month, Day, Year) FEB 1 6 State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

NOMAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THANWY

2005

DHMH 17 Rev 1/2001

300 AURORA

32. Resistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ST

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

47924

CAMBRIDGE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Registrar 2/15/05 AAOO HEALTH DEPT. OMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** uTurecar 5. Social Security Number 7. Age (In yrs. last birthday) If Under f Under 24 Hrs. 102M 2□ F Days Months Hours 89 Director Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Itams 23s or 28s-f show Maryland A Queen Armes 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10g. Citizen of What Country? 128 Koad permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural, or Itams 23s any injury or other fraumatic avant. Its Medical Examenations. Once. Vec 12. Was Decedent Ever in U.S. Amer Forces? 1 EYes 2 No. 1 Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ohns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 □ Cremation ` 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Appr imate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician eumor /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the factor of the Cause (Disease or injury that initiated events resulting in death) Last burial-transit been signed by the attending physician and should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760 nsion Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ congrotive 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perforn 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Director: After this certifica 25. Was case referred to medical examiner?
1 \(\text{Yes} \) 2 \(\text{No} \) 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of eath 1 Natural Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License numbe 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type February & Con MD 860)

FEB 15

32. Regi

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** JAMES C. KRECKEL FEBRUARY 13,2005 2:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ELLICOTT CITY HEALTH & REHAB.CENTER HOWARD ELLICOTT CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 89 Yrs. Director 196 10 8096 OCT. 25, 1915 PENNSYLVANIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or Itams 23a or 28a-f show othar traumatic event, I've Modical Examination was be molified at 1 ☐ Yes 2 ☐ No Director MARYLAND ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9006 ELMONTE WOODS WAY 21042 UNITED STATES Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TAXI DRIVER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CARL KRECKEL PEARL AUKAMP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES P. KRECKEL (SON) 9006 ELMONTE WOODS WAY ELLICOTT CITY, MD. 21042 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department of Important: If any injury or once. ^ 4 ☐ Donation 5 ☐ Other (Specify) FT.LINCOLN CEMETERY 2-15-05 BRENTWOOD, MARYLAND 22. Name and Address of Facility GEORGE P.KALAS FUNERAL HOME 21. Signature of Europa 2973 SOLOMONS ISLAND ROAD, EDGEWATER, MD.21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Aspiration Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Card wordcular **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and the detached for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) I□Yes 2□No 9 Unknown 9 □ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Wunknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No 2 🗆 No 1 Yes 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hours after death. Inaral Diractor: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death 28h Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral 6 Hospital Table 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mus FEBRUARY 14,2005 Baltimer Maylad 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3400 Erdman Avenue amesh Sabapalhi 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State FEB 1 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** FEBRUARY 9, 2005 7:10 A M VIRGINIA MARIE KNIGHT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CORSICA HILLS CENTER CENTREVILLE QUEEN ANNE'S If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months 1 M 2 X F 88 Director JUNE 26, 1916 IOWA 480-01-6121 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show it. Pages 1 and 2 should be filed within 72 hours after death with the Marylai kirment of Health and Mental Hygiene. krient: If item 27 is marked other than "natural", or Items 23a or 28e-f show niury or other traumatic event, It's Madical Examiliar is ust be notified at 1 Yes 2 No Director QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 LAIRD BENTON ROAD 21666 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Yes Give 1 ☐ Yes 2xXNo Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER SELF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRED STRAUSS ANN (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KURT D. KNIGHT / SON 143 ISLAND VIEW DRIVE ANNAPOLIS, MD 21401 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 2/10/05 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CENTER, LLC STEVENSVILLE, MD Department Importent: If any injury or once. ° 4 ☐ Donation 21. Signature of Femeral Service Licensee permit. FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician morardo Ihr /Medical Due to (or as a consequency of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Wes decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) as been signed by the a 2 should be detached o ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records. 1 🗆 Yes 2 340 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 2∏ No 1 ☐ Yes 2 ☐ 100 1 Tyes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 ☑ No Certification: To 4 rsing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury af Work? 28d. Describe how injury occurred After 1 Matural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: / the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ö To the Hospitel of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature affilt title of 29c. License number 29d. Date signed (Month, Dev. Year) 3 2036 2005

State Registrar 30. Name and address of pe

31. Date filed (Month, Day

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Drive Chihu, MD 21419

who completed cause of death (Item 23a) (Type, Print)

VOI

0 32. Regulari's Signature

			1 - For State Registrar	State of Ma	aryland		artment rtificate			nd Me		giene	2 1 1	5	0732	5
	Physici /Medio			INIA	LEV	VIS				F	. Date of Dea Month 'ebruar	y 1	5 20		3. Time of Death	М
	Examir	ier	4a. Facility Name (If not institution, give Montgomery Villac	e Health				tgom	Location of	illag			County of	omer	У	
	Funeral Director		5. Social Security Number 579-05-2062 Usual Residence of Decedent	7. Ag	e (In yrs. 18 87	ast birthday) Yrs.	Months	Days	Hours	Min.	Date of Birti (Month, Day June 1	/, Year)	17	Counti Mary	ace (State or Forei ry) 71and	ign
	Maryland	tor	10a. State 10b. County Md. Montgor	mery		Town or Lo		e						10	d. Inside City Limi	
	3a or 288	il Director	10e. Street and Number 23520 Pocahontas	Drive			10f. Zip	Code	2088	2		_	zen of Wha		•	
036	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show calcal Executive fourth be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Amed Forces? 1 Yes 2 1/2 If Yes, Give Year or Dates:			Was Deced If Yes, spec		spanic Origi n, Mexican, Specify:	in? (Specif Puerto Ric	ly Yes or No- can, etc.)		14. Race - Black, ' Specify:	White, e		
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Maryland 21	2 should be filed with and Mental Hygiene I's markad other the raumatic evant, the	To Be Co	11 17. Father's Name (First, Middle, Last) Lee Ward	0		Be	autic			's Name (F	First, Middle,			Sho	q	
	es 1 and 2 should b of Health and Menti 1 item 27 Is markad rr other traumatice		19a. Informant's Name/Relationship (T Patricia B. West		er						Route Numbe				Code) 20882	
Baltimore,	Pages 1 a nent of Hei nnt: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 💆 Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Ce	ace of Disponentery, crer	natory or ot	her place	´	Date 2/15/			cation - Cit exand			
Balti	permit. Pages 1 Department of H Important: If ite any injury or otl		21. Signature of Funeral Service Licens Muruef W-				Name and Muri	Address e L H	of Facility Bar	ber I	Tunera Layton	1 Ho	me		20882	
	Friysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the cause on each line. a	CARD	IAC AF		of dying	, such as ca	ardiac or r	espiratory ari	rest,		- 1	Approximate nterval Between Onset and Death	
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D	quires that n signed by	by	Part II. Other significant conditions co	ntributing to death b	ut not resu	lting in the u	nderlying ca	use give	n in Part I.			bacco u es 2[cause of death?	vn
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of Vita	Physician: this certific ral director,	To Be	1 Lifes 218 No	Hospital: 1 🗀 Inpatie		ER/Outpatien		A Other	4 🛭 Nurs	sing Home	Check only or 5 ☐ Resid	ence 6		Specify)		
Division (if in a	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injui (Month, Day	y Year)	28b. Time of Injury	М	_	at ? es 2 □ No	0	d. Describe h					
Dİ	in die		4 Homicide determined	28e. Place of Injubulding, etc	c. (Specify))					City or Tow	n, State,)		Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Aedicai	(Check only 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examinati		vestigation,	in my opi	nion, death		at the time, o	late and	place, and	due to t	he cause(s)	
)	S on T with	M	29b. Signature and title of certifier	sid	MJ	D	29c.	License	number 550)5L			e signed (M		ay, Year) 15, 2005	
			30. Name and address of person who carran KASID, M.D.			23a) (Type, EDLANI	-), I	ROCKVI	[LLE,	MD.	208	355			
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 6 20	32 Registra	ar's Signati	Le do	well					-				

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) John Arthur McGreevy, Sr. 4a. Facility Name (If not institution, give street and number) 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Funeral Director Funeral Director 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10d. Inside City Limit				26 per Verb., 68				Mental Hy	gien	e	0700
Physician Plant and Plant						imoute of	Dodin			<u>«. UUJ</u>	3 Time of Death
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### 46-25 Fawn Grove Road 219-10-229 Sum all processing of the						4h City Town	or Logation of Do				5:20a "
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Description of a state of the s	dea ctor y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home.	farm stre			28f. Location (5	Street ar	nd Number or Rura	I Route Number
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janne Olson 36 Works Lane Fawn Grovz Pa. 17321 State 31. Date filed (Month, Day, Year) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	after Dire	erti	4 Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	ot, lactory, office	,				r route ruiliber,
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			31. Date filed (Month, Day, Year)	2. Registrar's Signature	Anan	13					

DHMH 17 Rev 1/2001

Physici	an I	1. Decedent's Name (First, Middle, Last) Iris Virginia	M				l N	ate of Deat Month	Day	Year	3. Time of Dea
/Medi	cal	Iris Virginia 4a. Facility Name (If not institution, give street	Morri	.s	4b. City, Town,	or Location		ruary	17, 20		4:45
Examir	ner	Health South Chesapea		itatio		lisbur			Wico		
Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under	24 Hrs. 8. D	ate of Birth Month, Day,			ce (State or For
Director		215-26-7243 Usual Residence of Decedent	75	Yrs.				20/19:			yland
Mo T		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					100	d. Inside City Lin
a-f sh	ctor	Maryland Wicomico	_	Salis	sbury						1 ☐ Yes 2X
or 28	Dire	10e. Street and Number			10f. Zip Code			10	0g. Citizen of W	hat Country	y?
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rhem	Fun	1 Never Married 2 Married 1	med Forces? □Yes 2⊠No		Was Decedent of f Yes, specify Cul			n, etc.)		k, White, etc	c.
ral, o	þ		Yes, Give ear or Dates:		1 ☐ Yes 2XINo	Specify:			Specify:	whi	te
and Mental Hygiene. Is marked other than "natural", aumatic event, Ite Musical Ext	Completed	15. Decedent's Education (Specify only highest grade com	pleted)	(Give	dent's Usual Occu kind of work done DO NOT use retire	durina mos	at of working		16b. Kind of Bu	siness/Indu	stry
than	dmo	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)	Secre		94)		l	Produce	e Grov	vers
other other	Be C	17. Father's Name (First, Middle, Last)	<u> </u>			18. Mothe	er's Name <i>(Fir</i> s	st, Middle, M	Maiden Surname	θ)	
Menta arked atic e	70 E	E. Sampson Perdue				Mat	tie B.	Shay			
ls m	1	19a. Informant's Name/Relationship (Type, Pa	•		ng Address (Stree						
of Health and Mental Hygiene. item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I're Maylcal Ext. itrust institutional at		Earl B. Morris/husb	20h F	Place of Disno.	320 Mt. 1		Rd., S	Salish	oury, MI 20c. Location - 0	2180 City or Town	0. State
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			1- For State of Maryland / Department / Department / Department / Department / Department / Depa	artment of Health and M		ene No.2005 0732	Q
			Decedent's Name (First, Middle, Last)	Timodio or Bodin	2. Date of Death	3. Time of Death	<u> </u>
	Physicia /Medic		Jane Elizabeth McKean Moor	e ·	February	Day Year 12:30 P	M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	/	4c. County of Death	
Y,			Doctors Hospital	Lanham		Prince George's	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y May 27, 1	(ear) 9. Birthplace (State or Fore	ign
	Director		062-12-1105 93 Yrs. Usual Residence of Decedent		May $2/,1$	911 New York	
	ow ow		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Lim	its
	Mary First	to	Md P.G. New Ca	rrollton		1 X Yes 2 □	No
	death with the Maryland ms 23a or 28a-f show r.must be notified at	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?	
	23a (7516 Riverdale Rd.	20784		U.S.A.	
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc. 	
5	s afte	by Fi	1 □ Never Married 2 □ Married 1 □ Yes 3 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ② No Specify:		Specify: White	
2-003p	be filed within 72 hours after death with the Marylan tal Hygiene. d othar than "natural", or itams 23a or 28a-1 show avant, the Medical Examinar must be notified at	ed b		dent's Usual Occupation	16	8b. Kind of Business/Industry	
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7	d with giene ir tha	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Clerk		D.C. Gov't.	
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Mar	es 1 and 2 should b of Health and Menti fitam 27 is markad r othar traumatic a			ng Address (Street and Number or Rural			
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g C	permit. Deportr Imports any nij		Thomas S Chamber 5	2. Name and Address of Facility hambers Funeral Ho: 801 Cleveland Ave.	me & Crei Riverda	matorium,P.A. le, Md. 20737	
			25a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	r respiratory arrest	t, Approximate Interval Between Onset and Death	
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X Q Q	th ce tendii or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of delivery Month Day Year	
	at the dea by the at tached fo	/slcl	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		World Day Tour	
7	hat th od by detacl	Ph)	Part II. Dther significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I	23e. Did tobac	 cco use contribute to the cause of death?	
cords,	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the	ed by				2 No 3 Probably 4 Unknow	WΠ
ပ္	law re as be 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings availal prior to completion of cause of	ole of
r	sician: The law certificate has b irector, page 2 s	Com			performe	d? death?	
VII	cian: artific ctor,	Be (25. Was case referred to medical examiner?	26. Place of Death			
0	Physician: r this certific ral director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ☐ ER/Outpatien				
	ing After une	inol.	27. Manner of Death 1	Work?	8d. Describe how	injury occurred	
<u>s</u>	or Attending ifter death. Diractor: After in by the fune	lcat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str		P8f Location (Street	et and Number or Rural Route Number,	
DIVISION	il or Attend after death Diractor: ,	Certification:	4 Homicide determined building, etc. (Specify)	eet, factory, office	City or Town, S		
	Hospital 24 hours a Funaral tely filled		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deat	h occurred at the time, date and place, a	and due to the caus	se(s) and manner as stated.	- 11
	To the Hospital of within 24 hours at To the Funeral Completely filled in	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date	and place, and due to the cause(s)	
	To tha within 2 To tha complet	ž	29b. Signature and Affle of certifier	29c. License number		. Date signed (Month, Day, Year)	
	/		I wand Alaw, MD	D0058275		2-16-05	
	>		30. Name and address of person who completed cause of death (Item 23a) (Type, PARAND ALAVI, MD \$118 GCODLUCK R	d. LANHAM, MD 2	6766		
	Sta Registr		31. Date filed (Month, Day, Year) 33 Registrar's Signature FEB 1.7 2005				

McKean Moore

			1 = For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I			ene 3. N2 () ()	5_07329
	Dharisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Y	3. Time of Death
	Physici /Medic		Ruth Glenn		Moore			February	15 200	5 3:00 A M
	Examin		4a. Facility Name (If not institution, give)		or Location of Death	1	4c. County of	
				ane		Frost		T	Alleg	
	Funeral Director		5. Social Security Number 6. Sec. 215–14–6351		ge <i>(In yr</i> s. <i>last birthday</i> 83 Yrs.	Months Days		8. Date of Birth (Month, Day, OCL 28	(ear) 1921	9. Birthplace (State or Foreign Country) Maryland
	P ,		Usual Residence of Decedent		100 City T					10d. Inside City Limits
	Marylar s-f show	tor	MD. 10a. State 10b. County Allegai	ny	10c. City, Town or L	tburg				iv⊠¥es 2 □ No
	n with the	al Director	10e. Street and Number 136 Teaberry	Lane	•	10f. Zip Code 215	32	10	g. Citizen of Wh United	
936	72 hours after death with the Maryland Insturat', or Items 23e or 28e-f show disal Examinar must be motified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. White
21215-0036	ithin han '	Completed by	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) unknown		(Giv.	edent's Usual Occu e kind of work done DO NOT use retire Custodiar	during most of wor ad)	king	School S	•
Maryland 2	12 should be filed w h and Mental Hygie f is marked other ti reumatic event, th	To Be Co	17. Father's Name (First, Middle, Last)	ardson			18. Mother's Nan Pear	ne (First, Middle, M. L Rich	aiden Sumame) nardson	
Mary			19a. Informant's Name/Relationship (7 Carol Goldswor			•		oral Route Number, Ostburg, 1	•	
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 in iry or other tre		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Disp cemetery, cre		nce) 02	Date 21 /18/ B:	Oc. Location - Ci	ity or Town, State Maryland
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licen	see Sa	1	22. Name and Addr	D. 1994 - 1.0	oal Funer	- 10 to 0 - 10 to 0	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compandock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. A sach	d the death. Do not er		ing, such as cardiad		it,	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, it any, teading to introduct cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	c	s a consequence of):					
P.O. Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 ☐ Fetal death 3	□Ectopic pregnand □ Other (specify) _	ey		23d. Date o Month	•
	w requires that been signed b should be deta		Part II. Other significant conditions of		but not resulting in the	underlying cause g	ven in Part I.	23e. Did toba	20.0	ute to the cause of death? Probably 4 Unknown
of Vital Records,	:: The law re icate has bee r, page 2 sho	Completed by	NOT KNO	WN.	<u></u>			24a. Was an autopsy perform	ed? dea	ere autopsy findings available or to completion of cause of ath?
ita	ysicien: is certific director,	Be (25. Was case referred to medical examiner?					th (Check only one		
*	Physicien: r this certifica ral director,	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat				lome 5 Residen		
	ding Afte fune		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, D	ay Year) 28b. Time Injury	Wo	iryat ork?]Yes 2 ∐No	28d. Describe hov	v injury occurred	
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	286. Place of II	njury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office		28f. Location (Stre City or Town,	et and Number State)	or Rural Route Number,
	le Hospit n 24 hour le Funere letely fille	Medical (29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam one)	ysician: To the bes niner: On the basis and manner s	t of my knowledge, dea of examination and/or i tated.	ath occurred at the to	ime, date and place opinion, death occu	, and due to the cau rred at the time, dat	ise(s) and mann e and place, and	ner as stated. d due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	1-1	1	29c. Licen	se number	29	d. Date signed (Month, Day, Year)
1			1 Str	x SI	20-11-	DO	054004		2/13	5/2005
	5		30. Name and address of person who Dr. Shiv Khanna			, Print)	ale, Md.	21502		
	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 7		trar's Signature					

			1 - For State Registrar	State	of Mary		artment of H <i>rtificate of L</i>		and M		ene g. No. 0	05	07330
	- J. B.	774	Decedent's Name (First, Midd.)	le, Last)						2. Date of Death Month		Year	3. Time of Death
	Physicia /Medic		Hilda Lee N	McClurg						February			9:07 A M
	Examin		4a. Facility Name (If not institutio	-			4b. City, Town, or		f Death			y of Death	
			Anne Arundel Me			and the state of the	Annapo	lis If Under 2	24 Hrs	O Date of Birth	Anne	Arun	
	Funeral Director		5. Social Security Number 154–16–8285	6. Sex 1 ☐ M 2 🛣 F	7. Age (In	yrs. last birthday) Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day,		Cour	
			Usual Residence of Decedent		_03			l		3-28-192		ATL	ginia
	nyland how		10a. State 10b. County	1	100	c. City, Town or Lo	ocation					1	I Od. Inside City Limits
	e Ma Se-f s	cto	Maryland Anne	Arundel		Annapo	olis						1 ☐ Yes 2X No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	ntry?
	s 23c	Funeral Directo	1930 Marconi (Circle 12. Was Dec	adant Ever	in II S 12	Was Decedent of Hi		nin? /Sne	ncifu Vac or No-	USA 14 Ba	ce - Americ	can Indian
	after deal or Items	-un	11. Marital Status 1 □ Never Married 2 □ Mar	Armed F	orces?	110.5.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican	, Puerto I	Rican, etc.)		ack, White,	
920	urs af	by	3 Widowed 4 □ Divorced	If Yes. Gi	ive		1 ☐ Yes 2 【XNo	Specify:			Speci	h: Wh:	ite
21215-0036	be filed within 72 hours after death with the Maryland ital Plygiene. bd other then "neturel", or Items 23c or 28e-1 show event, the Medical Examinat must be notified at	Completed	15. Deceder	nt's Education ast grade completed))	16a. Dece	dent's Usual Occupa	ation	t of worki	na 1	6b. Kind of I	Business/In	dustry
7	within ene.	nple.	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired,)					
2	e filed w Il Hygier other tl		12th 17. Father's Name (First, Middle,	(201)		Secr	etary	18 Mothe	r's Namo	(First, Middle, N		lishi	ng
anc	ould be fi Mental H arked of atic ever	Be o	Carl Holm							e Austir		may	
Maryland	# B E E	10	19a, Informant's Name/Relation:			19b. Maili	ng Address (Street a					ı, State, Zip	Code)
<u>⊠</u>	nd 2 suith ar		Gilbert L. McCl			220	6 Huntfie	ld Ct	., G	ambrills	, MD	21054	
ē,	s 1 and 3 if Health item 27 other tr		20a. Method of Disposition			Ob. Place of Dispe				_	Oc. Location		own, State
E			1 ☐ Burial 2/☐Cremation 1 ☐ Donation 5 ☐ Other (State	Kalas Cr		. 1	-16-	05	Edjewa	ater.	MD
Baltimore,	permit. Pages Department of Huportent: If ite any injury or of once.		21. Signature of Funeral Service	Licensee		2	2. Name and Addres				alas 1	Tunera	al Home
8	pern Dep Imp		Wall bull	1/2		2	973 Solom	ons_I	slan	d Rd. Ed	lgewate	er, M	0_21037
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			disease or condition resulting in death)	_ a. 7 CU	15/	、//ンン//// ///		/ / / / /			/ I KT VV	1/-	וע וארו עו
	/Medical		1000 mily	Due to	(or as a co	onsequence of):	.701(1		1 12	33 34 10		1/-	1- 12-12
	/Medical Examiner			Due to	PAS a co	onsequence of):		1)13	NIC	33 3410			2 WEEK
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item/19a per State of Maryland / Department of Health and Mental Hygiene 1- For Fun. Dir. 2/22/05
1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death
Reg. No. 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 13 2005 **Physician** 5:31P^M JAMES K. MAVRIANOS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CROFTON ANNE ARUNDEL 2406 YARMOUTH LANE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) AUG. 11,1961 9. Birthplace (State or Foreign PENNSYLVANIA **Funeral** Days **№** M 2□ F Hours 210 46 4526 43 Yrs Director Usual Residence of Decedent ie filed within 72 hours after death with the Maryland al Hygiene.
I other then "natural", or items 23e or 28e-1 show 10c. City, Town or Location 10d. Inside City Limits 10a. State 27 is marked other then "natural", or items 23e or 28e-f show treumetic event, the Medical Examinar must be inclified at 1

Yes 2□No PHILADELPHIA Director PHILADELPHIA PA. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19134 UNITED STATES 735 EAST TIOGA STREET Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: ģ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) VINTAGE TOY COLLECTOR-DEALER COLLECTIBLES 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I NICHOLAS MAVRIANOS ROSE KENDIGIAN ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALFRED J. KAMAJIAN (COUSIN) 2406 YARMOUTH LANE CROFTON, MD. 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Department of Importent: If any injury or once. ¹ 4 □Donation 5 □ Other (Specify) LAWNVIEW CEMETERY 2 - 18 - 05ROCKLEDGE, PA 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 21. Signature of Funeral Service Licenses 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MESOTHELIOMA towam81 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2/No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 Yes 2/2/N certificate 1 Yes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cousin s Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Hospital: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) strar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 16

2005

State Registrar

Funeral

Director

Hygiene. other than "neturel", or items 23a or 28e-f show rent, the Msuitcal Examiner is ust be indiffed at

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Physician /Medical

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The law requires that the death certificate be executed

Fo the Hospitel or Attending Physician:

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

			1 - For State of Maryland / Department / Department / Department / Department / Department / Dep	artment of Health and Me rtificate of Death		ene2 () () 5	07333
			Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Physicia		Joan Ellen Menard	F	ebuary	5 2005	6:45 AMM
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	0.5 444_1	4c. County of Death	
	Examin	er	3815 Mt, Airy Drive	Mt. Airy		Carroll	
	E		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		B. Date of Birth		place (State or Foreign intry)
	Funeral Director		578-38-6028 1□ M ŽŪ F 76 Yrs. Usual Residence of Decedent	Months Days Hours Min.	(Month, Day,	Year) Cou 1928 Washii	ngton DC
	and w		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary f sh	ō	Maryland Prince Georges Riverdal	le :			1 □ Yes 💥 No
	r 28a-f show	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	with Sa or		5003 Tuckerman St.	20737		United Stat	
	leath	Funeral		Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri		14. Race - Ameri	
_	fter c	뎚	1 Never Married 2 Married 1 Yes 2 No		ican, etc.)	Black, White	
3	ars a	þ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🗓 No <i>Specify:</i>		Specify: W	nite
7	filed within 72 hours after death with the Maryland Hygiene. sther then "netural", or Items 23a or 28a-1 show ent, It e Medical Examinar must be notified at	Completed		dent's Usual Occupation	1	6b. Kind of Business/Ir	ndustry
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7	d wit	Ö		fice Administration	n :	Federal Gov	vernment
Þ	othe vent,	e C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M	laiden Surname)	
<u>ā</u>	should be nd Mental marked o	To Be	George Shibley	Helen	Newton		
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or Rural I	Route Number,	City or Town, State, Zi,	o Code)
	and 2 ealth a n 27 is		John M. Menard (Son) 3815	Mt. Airy Drive Mt.	. Airy	Maryland 21	771
Baitimore,	s 1 a of Hei		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Damatory or other place)	te 2	0c. Location - City or T	own, State
Ë	Pages nent of int: If it		1 Burial 2 N Cremation 3 Hemoval from State	g Crematory Feb 7	2005 -	Smithsburg	Maryland
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ñ	permi Depa Impo any it	1	Dungland Time 13	331 Eastern Blvd. N			
			23a, Part1, Enter the disease, or complications that caused the death. Do not ent				Approximate
	Dhamisian		shock, or hear failure. List only one cause on each line. Immediate Cause (Final	DECOM AS ALL D			Interval Between Onset and Death
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7	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
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ĕ	e la has je 2	Ę.			autopsy	prior to co	empletion of cause of
<u></u>		O			1 ☐ Yes 2	No 1 ☐ Yes	2 No
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	0	29a. Certifier Certifying Physician: To the best of my knowledge, deat	n occurred at the time, date and place, an	d due to the car	ise(s) and manner as a	stated
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	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
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	11		30. Name and address of person who completed cause of death (Item 23a) (Type,			1 1- 2	
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	Sta	te.	SUNCIN KUMAN MUTTAFILE 4203 Q 31. Date filed (Month, Day, Year) MAR US 2005	Colodala Kar, AA	MAINI	(141)	20781
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		e gr	Registrar 1. Decedent's Name (First, Middle, La	notl		Cei	tificate	OI L	yeam		2. Date of De.	Reg. No. Sa	-000	3. Time of Death
F	Physici	an	Esther Beatri								Month	Day	Year	
	/Medic		4a. Facility Name (If not institution, gi		ne)		4b. City, To	um orl	ocation o		Februar		2005 ounty of Deatl	11:50 AM
	Examin	er	21906 Newtown N		")				ltown				St. Mar	
E.	unaral				Age (In yrs. la	ast birthday)	If Under 1	Year	If Under 2	24 Hrs.	8. Date of Birt	h		
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er de	Itam	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Force 1 ☐ Yes 2 [s?	5. 13.	f Yes, specify	Cuban	, Mexican	, Puerto	ecify Yes or No Rican, etc.)	* 14	 Race - Amer Black, White 	
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e, l 1 and Health	itam 27 r other tra		Phyllis Abell	/ Daughte		-	Box 8		Leoi		town, M		0650	
Baltimore,	Important: If item 27 is marked other then "neturel", or Items 23a or 28a-1 show any injury or other traumatic avent, It's Madical Examinational be multified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [te ce	metery, crer	natory or othe	er place,	1			200. L00a	ation - City or	own, State
t: Pa	Important: If i any injury or once.	9	* 4 □ Donation 5 □ Other (Spec 21. Signal of Funeral Service Light	-	St	\ Cer	Xavier netery				2,2005	Compto	n, Maryl	and
Baltii permit. I Departm	Impo any ir		21. Signature of Funeral Service Line	-X7-	1		l Name and A latting	gley	z-Gar	, dine	r Funer	al Ho	ome, P.	Α.
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Division of Vital Hospital or Attending Physician: 4 hours after death.	To tha Funeral Diractor: completely filled in by the	edical	29a. Certifier 1 Certifying P	hysicien: To the be miner: On the basis	st of my knov	vledge, death	occurred at	the time	, date and	d place,	and due to the	cause(s) a	nd manner as	stated. to the cause(s)
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			For State	State of Maryla	-	artment of F			lie II	
			Registrar 1. Decedent's Name (First, Middle, i	Last)		Tanoato or	Doutin	2. Date of Dea	ath Z 0 0 5	3. Time of Death
	Physici		Daylin	L. MOR	010	5D		Honth	Day 14 200	5 11:30 PM
	/Medio Examin		4a. Facility Name (If not institution, g		<u> </u>		r Location of Deat		4c. County of De	
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	Funeral			. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs			irthplace (State or Foreign Country)
	Director		218 607890	1) M 2 F 4	Yrs.	Months Days	Hours Min.		27 1955	Virginia
	pu ,		Usual Residence of Decedent 10a, State 10b, County	100	City, Town or L	anation .		/		
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	he M	ecto	MD Worce:	ster	Ocean F	10f. Zip Code			10g. Citizen of What	
	with a or 3	급	29 Canal Road			21811			US	Sountry ?
	eath	eral	11. Marital Status	12. Was Decedent Ever in	1U.S. 13.		lispanic Origin? (S	Specify Yes or No-		nerican Indian,
21215-0036	be filed within 72 hours after death with the Maryland hal Hyglene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕱 No		to Rican, etc.)	Black, Wi Specify: W	nite, etc.
Ģ	2 ho	ted	15. Decedent's	Education	16a. Dece	edent's Usuaf Occup e kind of work done	ation	rkina	16b. Kind of Busines	s/Industry
泛	within 7 ene. than "r	ble	(Specify only highest (Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	ikiig		
	filed wi Hyglen other th	Completed		2	Main	tenance S			Restaura	nt
nd	be filed tal Hygid d other evant, III	Be	17. Father's Name (First, Middle, La						Maiden Sumame)	
∑ Z	2 should be and Mental Is marked aumatic ev	ဥ	Boyd Hall Morr				Jean B			
Maryland	s 1 and 2 should if Health and Men itam 27 Is marke othar traumatic		19a. Informant's Name/Relationship		1				r, City or Town, State	, Zip Code)
	s 1 and 3 Health itam 27 othar tr		Kimberly Morris 20a. Method of Disposition			Canal Rd.	, Ocean	Pines, I	Md. 21811 20c. Location - City (or Town State
altimore,	Pages nent of I int: If its iry or o		1 Burial 2 Cremation 3	☐Removal from State	cemetery, cre	matory or other pla		7-05		
Ħ	t. Partmer rtant rtant		' 4 □ Donation 5 □ Other (Spe		cape He	nlopen C	rematory		Frankford	, Delaware
Ba	permit. Pages Department of Important: If it any Injury or o once.		21. Signature of Funeral Service Lic	4 Raffel	4	<u>08 William</u>	St., Be	<u>erlin, Mo</u>		I Home
т			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused the de thy one cause on each line.	eath. Do not en	ter the mode of dyir	2 /			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Motosto	tic 1	Kerel	Care	moma		Onset and Death
	/Medical		resulting in death)	Due to (or as a cons	sequence of):					1
	Examiner	l. l	Sequentially list conditions.	b						
	ייי קד. פייי קד	iner	Sequentially list conditions, harry, leading to mini solute cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	ведиалеа обр					
	ecute and -trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons						
90	ate be executed hysician and the burial-transit			Due to (or as a cons	sequence or).					
8760,	physics the b	Physician/Medical		d.						
9 ×	death certificate e attending phys d for use as the	/Me	IF FEMALE:	23c. If yes, outcome of pred	ananav					
Вох	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 F	etal death 3[Ectopic pregnancy	1		23d. Date of d Month	elivery Day Year
o.	the de	ysic	1 Yes 2 No	4□Pregnant at time of 9□ Unknown	ordeath 5	Other (specify)				
Δ.	that ad b deta		Part II. Other significant conditions	s contributing to death but not	resulting in the t	undertying cause gr	ren in Part I.	23e. Did to	bacco use contribute	to the cause of death?
of Vital Records,	es be	d by			_	, ,		1 □ Y	es 200 3□	Probably 4 Unknown
Ö	> 0 70	Completed						24a. Was a	an 24h Word	autopou findinge quallable
3e	e fav has je 2	du						autop:	sy prior to	autopsy findings available completion of cause of
<u>a</u>	(Q							1 ☐ Yes	No 1□Ye	as 2 21 No
<u>=</u>	Physician: rthis certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:		-t 35 pos Ott	er	ath (Check only or	/	
of		-	1 Yes 22 No	28a. Date of Injury	ER/Outpatie	III 3 DOA	4 Nursing F		lence 6 Other (Sp low injury occurred	ecity)
on	ding Fin. After funera	tior	1 Natural 5 Pending 2 Accident Investigat	(Month, Day Year,	fn j ury	Wor	k? Yes 2⊟No			
Division	l or Attanding after death. Diractor: Aftel In by the fune	fica	3 Suicide 6 Could no	t be 28e. Place of Injury - A	t home, farm, st	reet, factory, office		28f. Location (S	Street and Number or i	Rural Route Number,
S	in Signature	Certification:	4 Homicide	building, etc. (Spe	ecify)			City or Tow	n, State)	
	5 t 7 5	edical C	29a. Certifier Certifying (Check only one)	Physician: To the best of my learning: On the basis of examiner: and manner stated.	knowledge, deal ination and/or in	th occurred at the til nvestigation, in my o	me, date and place pinion, death occu	e, and due to the durred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To tha Hos within 24 h To tha Fun completely	Me	296. Signature and title of certifier	- 1/1/	/	29c. Licens	e number	2	29d. Date signed (Mo	nth, Day, Year)
)	~ > F 0	1 9	10/12	CHIM	9	1 1) 2	6278	3	2-1	5-05
			30. Name and address of person wh	no completed cause of death ((tem 23a) (Tvpa	Print)	5270		/ -	
7	H		DAVA CON 31. Date filed (Month DapYear)	2005 32. Sgistrar's Sig	P.O. A	60x 17	33 S	alish,	2-/3 ms	2/80/
	Sta Registi		on sale med has in Brain 6	2005	A K	barde		\bigcirc		

				1 - For Stata Registrar		ryland / C	Departme	ent of Health and ate of Death	Mental Hy	_	05 07336
				Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath	3. Time of Death
		Physici /Medi		Walter H. Manr	heimer				Februa:	ry 12, 2	Year 005 12:45 P. ^M
		Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. Ci	y, Town, or Location of Dea		4c. County of	
				Suburban Hospita		4		Bethesda		Montg	
		Funeral		5. Social Security Number 6. S 457–74–1019	Sex 7.Age	(In yrs. last biri 93	Yrs. Month	ler 1 Year If Under 24 Hr s Days Hours Mir	. (Month, Day	h y, Year)	Birthplace (State or Foreign Country)
		Director		Usual Residence of Decedent					June 24,	1911	Germany
		death with the Maryland oms 23e or 28e-f show it must be notified at	ctor	10a. State 10b. County Maryland Montgome	ery	10c. City, Town					10d. Inside City Limits 1 ☐ X es 2 ☐ No
		th with th	Funeral Director	1799 East Jeffer	son Street		10f. 2	Zip Code 20852		10g. Citizen of W United	
	36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-1 show any injury or other treumetic event, the Medical Examinat must be notified at ance.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	lo		edent of Hispanic Origin? (pecify Cuban, Mexican, Pue 2 🔥 No Specify:	Specify Yes or No- rto Rican, etc.)		- American Indian, K, White, etc. White
	15-00	n 72 hou "nature edical E	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	Decedent's Us (Give kind of s life, DO NOT	sual Occupation work done during most of we use retired)	orking	16b. Kind of Bus	iness/Industry
	212	within within the r	mo	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+) Aı		siologist		Medica	1
	Maryland 21215-0036	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last, Eugene Mannheim				18. Mother's Na Hedwig	weiss	Maiden Sumame)
	Mary	nd 2 shorth and N		19a. Informant's Name/Relationship (Irene M. Kirkpatr			-	ss (Street and Number or F		-	
	ē,	f Hea item		20a. Method of Disposition			Disposition (A		ruary15		City or Town, State
	Ë	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Cremation 3 ☐ Other (Specify)		Geo. Wa	ash Cent	iversity 20	05	Washing	ton, D.C.
	Baltimore,	permit. Departn Importe eny inju		ignature of juneral Service Licer	1see	dr	22. Name	and Address of FacilityCo	lumbia Mo 58007 Was	ortuary shington	Services, Inc., D.C. 20037
Ç		Pn ysicia n /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each in	Θ.	tmia-Ve	ode of dying, such as cardio entricular Ta			Approximate Interval Between Onset and Death Minutes
1245 p.m.	-	Examiner	70	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Ischem	ic Card	iomyopa	thy			Months
65 @ 124	8760,	certificate be executed iding physician and ise as the burial-transit	Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence o					
0	. 68	tificat ig phy as thi			<u> </u>						
3	O. Box	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 24□Pregnant at 9□Unknown	2 Fetal death	3 □Ectopic 5 □ Other (23d. Date Mont	of delivery th Day Year
	σ.	The law requires that the the has been signed by the bage 2 should be detache		Part II. Other significant conditions of	contributing to death bu	t not resulting in	the underlying	cause given in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
JAHE	ecords,	v requires been sign should be	ed by	Thrombocytos					1 🗆 Y	es 🖄 No 3	Probably 4 Unknown
=	00	law requir as been si 2 should	olete	Diabetes Mel	litus				24a. Was a	an 24b. W	ere autopsy findings available
3	Re	ticlen: The lav certificate has rector, page 2	Completed	Pneumonia					autop: perfor 1 Yes		ior to completion of cause of eath? ☐ Yes 2 ☐ No
_	ita	ortifica ctor, I	Be C	25. Was case referred to medical examiner?				26. Place of De	eath (Check only or		
5	of V	Physiclen: this certific ral director,	2	1 ☐ Yes 2 ☑ No		nt 2□ER/Out			Home 5 Resid	ence 6 Other	(Specify)
. E.		ding P h. After (tlon:	27. Manner of Death 1X Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. T	ime of njury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurre	d
Anuheiner	Division	or Attending after death. Director: Afte in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e One Diese of Injur	ry - At home, fai . (Specify)			28f. Location (S City or Town	treet and Number n, State)	r or Rural Route Number,
5	_	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical Co	29a. Certifier Check only one) Certifying Ph	nysician: To the best on the basis of and manner state	examination and	, death occurre	od at the time, date and place on, in my opinion, death occ	e, and due to the courred at the time, d	ause(s) and man late and place, ar	ner as stated. Indidue to the cause(s)
		To th withir To th comp	Me	29b. Signature and title of certifier	2-0			9c. License number	2	29d. Date signed	(Month, Day, Year)
)	12) E. P.	Libra	ZMI	0	D09470]	February	12, 2005
	_	10.2		30. Name and address of person who Eugene P. Lik	ore, M.D.		onnecti	icut Ave., Ke	nsington	, MD 20	895
		Sta		31. Date filed (Month, Day, Year) FEB 16 2	32. Pegistra	r's Signature	Spark				

			1 - For Stete Registrar	State of Ma	aryland / Dep <i>Ce</i>		Health ar			_	05	07337
	Dhysis		1. Decedent's Name (First, Middle, Last)					2	Date of Death	Day	Year	3. Time of Death
	Physici /Medi		LESLEY	BURCHELL	MCFARLANI)			FEB		005	5:10 P _M
	Exami	ner	4a. Facility Name (If not institution, give				or Location of I	Death		4c. County		
			NATIONAL NAVAL ME				ETHESDA				ONTGO	
	Funeral Director		5. Social Security Number 574-16-8794 Usual Residence of Decedent	TAL OFFIC	86 Yrs.	If Under 1 Yea Months Days		Min.	Date of Birth (Month, Day, Y Iay 21, 1	918	Cour	lace (State or Foreign try) hington, DC
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation					1	Od. Inside City Limits
	Mary -1 sh fied	to	Maryland Montgom	ery	Ве	thesda						Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g	. Citizen of	What Coun	try?
	h with	O E	5600 Ontario Circ	1e		208	316			U	SA	
	deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin	n? (Specif	y Yes or No-		ce - Americ	
9	after or ite	/Fu	1 Never Married 2 Married	1 ☐ Yes 2X N If Yes, Give	lo	1 ☐ Yes 2 ♣ No		ruento nic	an, etc.)		ck, White,	
8	nours urel',	d by	3 Widowed 4 Divorced	Year or Dates:		12 103 22110	o opecity.			Specif	y: W	hite
<u>7</u>	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or items 23e or 28e-f show ont, the Maulical Examinar must be maillied at	Completed	15. Decedent's Edu (Specify only highest grade	cation e co <i>mpleted)</i>	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retir	upation e during most o	f working	16	b. Kind of B	usiness/Ind	dustry
12	withil ene. then	d L	Elementary/Secondary (0-12)	College (1-4or 5	+) Homen	_	90)			Own	Home	
9	filed Hygi Sther ent, I	ပိ	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (F	irst, Middle, Ma			
lan	should be filed within and Mental Hygiene. marked other then imatic event, the M	To B	Norbal Landon B	urchell			Les1e	ey Ro	yster			
Maryland 21215-0036	- m -	_	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Stree	at and Number of	or Rural A	loute Number, C	city or Town,	State, Zip	Code)
	and 2 ealth a n 27 is	1 8	Earl McFarland, J	r./Husban	d 5600	Ontario	Circle,	, Bet	hesda,	Md. 20	0816	
ore.	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		20b. Place of Dispo cemetery, cre	sition (Name of matory or other pl	ace) I	Date Feb. 1	20	c. Location	City or To	wn, State
Ĕ	Pages nent of l		'4 □ Donation 5 □ Other (Specify)	emoval from State	Metropo1	itan Cre	ematory	2005	A	1exano	dria,	Va.
Baltimore,	permil. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre once.		21. Signature of Funeral Service licens	9111	2:	2. Name and Addi	ress of Facility	DeVo	1 Funer	al Hor	ne	
_	g Q E 9 9		23a. Part1. Enter the disease, or compli	la .		22 Wisco	nsin Av	Je.,N	W.,Wash	., DC	2000	7
	Fnysician /Medical Examiner	ner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cauts. Exist Underlying Cause (Disease or injury)	Due to (or as a	CONGESTIVE a consequence of):	E HEART I	FAILURE					Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):							
P.O. Box 6	the death certificy the attending parched for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	су				te of delive	ry Day Year
	quires that in signed t uld be det	by	Part II. Other significant conditions con	tributing to death bu	it not resulting in the u	nderlying cause g	iven in Part I.	_				e cause of death? ably 4 Unknown
Vital Records,	. The taw require cate has been si page 2 should I	Completed						[24a. Was an autopsy performer		Were autop prior to con death?	osy findings available appletion of cause of
Ta		CO	25. Was case referred to medical				Of Pines of	Dooth (C	1 ☐ Yes 2 ፟∆	No	1 🗌 Yes	2□ No
	Physicien: this certifical	0	eyaminer?	lospital: 1X Inpatier	nt 2 ER/Outpatier	nt 3 DOA	than		5 Residenc	e 6 TOth	er /Snecify	1
J of	g Ph	n:	27. Manner of Death	28a. Date of Injun (Month, Day					. Describe how			/
io	Attending Indeath. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(IMOITIII, Day	Year) Injury		Yes 2 □ No					
Division	F = C	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, str . (Specify)	eet, factory, office		28f.	Location (Stree City or Town, S	t and Numb itate)	er or Rural	Route Number,
	To the Hospitel of within 24 hours at To the Funeral D completely filled it	edical C	29a. Certifier 12 Certifying Phys (Check only one) 2 Medical Examin	sicien: To the best on her: On the basis of and manner stat	f my knowledge, deatl examination and/or in ted.	n occurred at the t vestigation, in my	ime, date and p opinion, death o	olace, and	due to the caus at the time, date	e(s) and ma and place,	anner as sta and due to	ated. the cause(s)
	To the within 2 To the complex	Me	29b. Signature and/title of certifier			29c. Licen	se number		29d.	Date signe	d (Month, D	Day, Year)
)	vo		Dill Due	MAMO	- was	010	1235480	O (VA) 0	2/14	1/20	7.0
	-		30. Name and address of person who co	repleted cause of de	eath (Item 23a) (Type,				NAVAL M	EDICA	L CEN	TER
					SN				MD 2088			
High	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 6 20	32. 5 gistra	r's Signature	reli						

			1 - For State Registrar		State of	Marylar		artmen <i>rtificat</i>				ental Hy	giene	11115	073	138
	Physic	an	1. Decedent's Name (First, M	iddle, Las	it)							2. Date of D			3. Time	of Death
	/Medi	cal	Rita L. Noone							. 1.15		ebruary	15,	2005	9:33	р м
	Examir	ner	4a. Facility Name (If not instit					,		Location of	of Death			. County of Dea		
	Funeral		Shady Grove Ac 5. Social Security Number	6. Se			last birthday)	If Under		If Under		B. Date of Bi	rth	lontgomer 9. Bi	thplace (State	or Foreian
	Director		179-18-3573	1	□M 2X□F	90	Yrs.	Months	Days	Hours	Min.	(Month, D	a <i>y. Year)</i>		o <i>intry)</i> sylvania	
	pu *		Usual Residence of Deceden 10a, State 10b, Col			100 Ci	ty, Town or Lo	anting							1404 1-11	21
	fanylan show	ō		,		100.01									10d. Inside (s 2 🖾 No
	28a-1	Director	Maryland Mr 10e. Street and Number	ntgom	ery		Gaith	ersburg 10f. Zip					10a Cit	tizen of What C		
	3a or		9723 Duffer V	lav				101. 210	2088	36			109. 01	USA	ouritry :	
	ms 2	Funeral	11. Marital Status	<u>a</u> y	12. Was Decede	ent Ever in U	.S. 13.	Was Deced			igin? (Spec	ify Yes or Nican, etc.)	D-	14. Race - Am		
98	be filed within 72 hours after death with the Maryland stal Hygiene. Individual than "natural", or Items 23a or 28a-1 show orther than "natural", or Items 23a or 28a-1 show event, the Medical Evanties must be redified at	/Fui	1 Never Married 2		Armed Force 1 Tes 2 If Yes, Give			If Yes, spec		n, Mexicar Specify:		ican, etc.)		Black, Whi		
8	ural',	d by	3₹ Widowed 4 □ Divor		Year or Date	os:								Specify: Wh:		
15	n 72 "nat	Completed	15. Dece (Specify only hi	dent's Ed phest grad	ucation de completed)		(Give	dent's Usua kind of wor DO NOT us	k done d	lurina mosi	t of working	7	16b. K	ind of Business	/Industry	
12	withing the second seco	шо	Elementary/Secondary (0-1	2)	College (1-4 5+	or 5+)		ntary S			her		Edu	cation		
b	illed Hygi other	Be C	17. Father's Name (First, Mid	ile, Last)			<u> Lear</u>	ileary i				First, Middle				
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ms	To B	Thomas Coakley							1	Kathry	n Winkl	е			
ar	2 should and Men Is marke		19a. Informant's Name/Relat											or Town, State,	Zip Code)	-
	and eelth m 27		Mary Alice Hoffm	an/Da	ughter 	1				, Gaitl		rg, MD				
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Monta Important: If Item 27 is marked any Injury or other traumatic enones.		20a. Method of Disposition 1 Burial 2 Cremati	on 3 🗔	Removal from Sta	ate	Place of Dispo cemetery, crea	matory or o	ther place		'ebruar	y 19,	20c. Lo	ocation - City or	Town, State	
Ħ	it. Partiment injury		`4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Sen			Gat	e of He				2005			ver Sprin	ng, Maryl	and
Ba	permit. Departr Imports sny Inju		21. Signature of Purieral Serv	C LICON	_0_							al Home				
			23a. Part1. Eliter the disease	, or comp	olications that cau	sed the deat								ng, MD 20	Approxima	ite
	Physician		Immediate Cause (Final	ist only o	one cause on eac	n line.	*								Interval Be Onset and	Death
	/Medical		disease or condition resulting in death)	-	aDue to (or	as a conseq	m (q								minu	103
	Examiner		Sequentially list conditions		b Hy	pert	en 510	-							year	2
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	cate be executed obysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	1	c. Due to (or	as a conseq	uence of):							_		
8760,	be ey	= E				as a conseq	derice or).									
687	ficate p physis is the	edical			d											
Вох	eath certific attending p	N/U	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outco			J=						23d. Date of de	livery	
	The law requires that the death certificate be executed to has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 Ø No			n 2 ∏ Feta tat time of d		Ectopic pre Other (spe						Month	Day	Year
P.0	at the de t by the s stached	Phys	9 Unknown				-									
	res tha signed to de	by	Part II. Other significant con-	titions co	entributing to deat	h but not res	ulting in the u	nderlying ca	use give	n in Part I.				ise contribute to	the cause of obably 4	
0.0	w require been sig	eted							-				Yes 2	□N0 3□P	robably 4 🗾	Unknown
Vital Records,	has t	ompleted										24a. Was		24b. Were a prior to death?	utopsy findings completion of a	available cause of
<u>e</u>		e Co	25. Was case referred to med	inal								1 ☐ Yes	2 No	1 ☐ Yes	2 □ No	
	Physician: ' this certifica ral director, p	o Be	examiner?	1	Hospital: 1 ☐ Inp	ationt 2.2	ER/Outpatier	nt 3 🗆 DO	Othe			Check on		6 □Other (Spe	-16-1	
o (g Phy er this	\vdash	27. Manner of Death	1	28a. Date of I		28b. Time of		Bc. Injury Work			d. Describe			спу)	
io	Attending r death. ector: After by the funer	atlo		stigation		Day 16ai)	Injury	М		r 'es 2□h	No					
Division	al or Attending P s after death. I Director: After t d in by the funera	Certification:		ild not be ermined	280. Place of	Injury - At he etc. (Specif	ome, farm, str	eet, factory,	office		28	f. Location (d Number or R	ural Route Nun	nber,
	oital o															
	e Hospital or 124 hours after Euneral Dire	edical	29a. Certifier 1 Certi (Check only 2 Madi	ying Phy al Exam	rsician: To the be iner: On the basi and manner	s of examina	wledge, death tion and/or in	n occurred a vestigation,	it the time in my op	e, date and inion, deat	d place, an th occurred	d due to the at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of cer	ifier	and manner	stated.		29c.	License	number			29d. Dat	e signed (Mont	h, Day, Year)	
)	F 5 F 8) (ia	m	San	da	MID) .	DE	90	29					nc
	/>		30. Name and address of pers	on who c	ompleted cause of	of death (Item	1 23a) (Type,	Print)	V	1.14			CEN	vary 1	- 100	
_			Aaron Snyder,	M.D.	9901 Medi	cal Cen	ter Driv	re, Roc	kvill	e, MD	20850					
	Sta		31. Date filed (Month, Day, Ye		Reg	strar's Signa	ture	de)								
	Registr	aı	FEB 1	200	JULION	N 10	1	- Carrier								

			1 - For State Registrar	State of	Maryland		artment tificate					iene _{eg. No.} 0)5	07339
	Physici /Medic		1. Decedent's Name (First, Middle, Mania	NADEL							2. Date of Deat		Year	3. Time of Death 2:10 A M
	Examin		4a. Facility Name (If not institution, Suburban Hospi		nber)			Town, or thes	Location o	of Death		4c. County Mon 1	of Death	ery
	Funeral Director		118-36-2249	.Sex 1 ☐ M 2 💢 F	7. Age (In yrs. las 91	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Aug. 27	Year)	Cou	place (State or Foreign ntry) and
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MOntgom	ery	10c. City Sil	Town or Lo ver S	cation pring							10d. Inside City Limits 1 ☐ Yes 2 💆 No
	h with the 23e or 28e	Funeral Director	10e. Street and Number 1110 N. Belgrade	Rd.			10f. Zip 20	Code 902			1.	0g. Citizen of V	What Cou	ntry?
036	filed within 72 hours after death with the Maryland Hygiene. ther than natural; or items 23e or 28e-f show ont, the Madical Examinational Committed at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed For	2 ∑ No ∍	'	Was Deced f Yes, spec	ify Cubar	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	Blac	e - Americk, White,	
21215-0036	be filed within 72 ho tal Hygiene. d other than "natur event, Itto Med Gal	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			life.	lent's Usua kind of wor DO NOT us ales	k done d	urina mosi	t of worki	ng	16b. Kind of Bi		dustry
Þ	m - 0 =	To Be C	17. Father's Name (First, Middle, La Moshe Konig							r's Name eah	(First, Middle, M Renn		лө)	
Maryland	12 should be f h and Mental h 7 is marked of traumetic eve	F	19a. Informant's Name/Relationshi Lily Greenberg	(Type, Print)							Route Number			
Baltimore, I	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumetic evence.	i ii	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Denation 5 Other (Spe	Removal from S	20b. Plac	ce of Dispo netery crer Par	sition (Nam	ne of	1	D		20c. Location -	City or To	own, State
Balti	permit. Departm Importa any inju		21. Signature of Cheral Shrussia	Byla		25	4 Car	rol1	St.	, NW	, Washin	gton, I		eral Home 0012
	Pnysician /Medical		23a. Part 1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	_a P	NEUM	ONI		e of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions,	b	or as a consequent		REN	AL	F	TAIL	wer			
8760,	cate be executed physician and the burial-transit	dicai Examine	Sequentially list conditions, flary, Laury to trimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequen	,								
.O. Box 68	The law requires that the death certifical tie has been signed by the attending phyage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Vio 9 ☐ Unknown	1 ☐ Live bi	come of pregnance onth 2 Fetal de ant at time of deat wn	eath 3	Ectopic pre Other (spe				1500	23d. Dat Mo	e of deliventh	ery Day Year
4	quires that in signed by uld be deta	by	Part II. Other significant condition	s contributing to de	ath but not resulti	ing in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	1/		ne cause of death?
Vital Records,		Completed									24a. Was ar autops perform 1 Yes 2	y ped?		psy findings available mpletion of cause of No
f Vita	Physician: T this certificat ral director, pa	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 1 In	patient 2 EF	VOutpatien	t 3 DO	A Othe	~		(Check only one		er (Specif	y)
ion of			27. Manner of Denth 1 Natural 5 ☐ Pending 2 ☐ Accident investiga		f Injury 28 n, Day Year)	8b. Time of Injury	28 M	Bc. Injury Work 1 🔲 Y	at ? 'es 2 □!		28d. Describe ho	w injury occurr	ed	
Division	Hospital or Attending 24 hours after death. Funaral Diractor: Afte tely filled in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	200. Flace	of Injury - At homo g, etc. (Specify)	e, farm, str	eet, factory	, office		2	28f. Location (Str City or Town		er or Rura	al Route Number,
	To tha Hospital or At within 24 hours after or To tha Funaral Dirac completely filled in by	Medical (29a. Certifier 11 Certifying (Check only one) 2 Medical E	Physicien: To the aminer: On the ba and mann	sis of examination	edge, death n and/or inv	occurred a restigation,	at the time in my op	e, date an inion, deat	d place, a th occurre	and due to the ca ed at the time, da	use(s) and ma ite and place, a	nner as s and due to	tated. the cause(s)
)	To that within 2. To that complet	Me	29b. Signature and title of certifier	Zma	٠ N.	D.		License	number 7 6	60	29	2/1	(Month,	
	7		30. Name and address of person w AUANA Gon	11 . " 1.		3a) (Type,	Print)	uvi	UE	PIK	F, Roc	wille	EM	020852
	Sta Registr	2 2	31. Date filed (Moath Day, Year), FEB 17	2005	egistrar's Signatur	60	will						,	

		- For	State of Mai	ryland / Dep		Health and	d Mental Hygi	ene 2005	07216
		1 - State Registrar	1		Timeate or	Dealli	2. Date of Death	g. No. ***	2 Time of Dooth
Physic	ian	Decedent's Name (First, Middle, Last	7				Month	Day Year	3. Time of Death
/Med		Harry E.	Na1	ty	1 2. 5		February 1		11:45 A M
Exami	ner	4a. Facility Name (If not institution, give				or Location of De		4c. County of Death	
		Montgomery Village He				omery Vi	.11age Irs. 8. Date of Birth	Montgome	
Funeral		5, Social Security Number 6. Se	x /. Age DM 2□F	(In yrs. last birthda) 87 Yrs.	Months Days		in. (Month, Day,		place (State or Foreign ntry)
Director		Usual Residence of Decedent		87			March 23	, 1917 Cold	ombia
land bw		10a. State 10b. County		10c. City, Town or I	ocation			1	0d. Inside City Limits
Mary 1 sh	Ď	Maryland Mont	cqomery	G	ermantown	1			1 ☐ Yes 2 ☐ No
the 286	Director	10e. Street and Number	3		10f. Zip Code	-	10	g. Citizen of What Cour	ntry?
3a ol		19215 Wheatfiel	d Drive		208	76		Jamaica	
be filed within 72 hours after death with the Maryland lat Hyglene. Id other than "natural", or Items 23a or 28e-1 show event, the Medical Evanfrer resist to notified at	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13	. Was Decedent of	Hispanic Origin?	(Specify Yes or No- ierto Rican, etc.)	14. Race - Americ	
<u> </u>	Ξ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 24☐ No					Black, White,	
hours after tural, or Ite	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 X Yes 2 ☐ No	э Ѕреспу: ч	Jamaican	Specify:Blac	K
IVIGITY IGITION AT A 13-10-00-00 of 2 should be filed within 72 hours at the and Mental Hygiene. 27 Is marked other than "natural", or treumatic event, the Medical Examption and the angle of the angle of the medical Examptical Exam	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dec	edent's Usual Occu	pation	working	6b. Kind of Business/In-	dustry
within 72 ene. than "nat	npie	Elementary/Secondary (0-12)	College (1-4or 5+) life.	e kind of work done DO NOT use retir	ed)			
filed wi Hygien other th	lo U	12		Me	chanic			Automobil	.e
at Hy	e e	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Middle, N	faiden Sumame)	
Z should be to and Mental is marked of reumatic eve	2	James Nalty				Rose	etta Green		
and and ls m	1	19a. Informant's Name/Relationship (T	ype, Print)	19b. Ma	ling Address (Stree	et and Number or	Rural Route Number,	City or Town, State, Zip	Code)
and and n 27		Marjorie Walker/D	aughter					town, MD 20	
partilliors, Mai yian permit. Pages 1 and 2 should b Department of Health and Ment Important: If Item 27 1s marked any injury or other treumatic e once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cr	position (Name of ematory or other pl	reb	pruary 18	Oc. Location - City or To	own, State
Pages ment of ury or of the	1	' 4 □ Donation 5 □ Other (Specify		Gate of H	eaven Cemet	ery 2	2005 s	ilver Sprin	g, Maryland
permit. Departr Import		21. Signature of Funeral Service Licens	600	I	22. Name and Add	ess of Facility.	s Funeral	Home Inc.	30.
D 89779		23a. Part1. Ententihe disease, or comp	Doday		00 Unive	rsity B1	vd, W., Si	lver Sprind	, MD 20901
ate be executed Wedical Wascian and Purisit ransit Ab burial-transit		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute M Due to (or as a Prostat Due to (or as a Hyperte Due to (or as a	yocardial consequence of): e Cancer consequence of):		ion			Onset and Death
the death certification by the attending place in use as t	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	☐Ectopic pregnan	су		23d. Date of delive Month	ery Day Year
es that igned b	y P	Part II. Other significant conditions co			underlying cause g	iven in Part I.	23e. Did tob	acco use contribute to th	ne cause of death?
aquire an sig	ed	Peripheral Vas	cular Dise	ase			_ 1 ☐ Ye	s 2 □ No 3 □ Prob	abiy 4 🔀 Unknown
vical necolor sicien: The law requir certificate has been si rector, page 2 should i	Completed						24a. Was ar		psy findings available mpletion of cause of
The lav	Eo						perform 1 ☐ Yes 🔀	ed? death?	
	(D)	25. Was case referred to medical				26. Place of I	Death (Check only one		
	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatien	t 2 ER/Outpati	ent 3 DOA	then: 4 XNursin	g Home 5 Reside	nce 6 Other (Specify	y)
Attending Pher death. **Cotor: After the by the funeral		27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time	of 28c. Inj		28d. Describe ho		
ath.	atic	1 X Natural 5 Pending investigation		,,,,		Yes 2 □ No			
	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, : (Specify)	street, factory, office	9	28f. Location (Str City or Town	eet and Number or Rura , State)	il Route Number,
rs aft	Cer		1				<u>N</u>		
To the Hospitel or within 24 hours affe To the Funerel Dir completely filled in	ledicai			examination and/or				use(s) and manner as si te and place, and due to	
To the within 2 To the complet	Ž	29b. Signature and title of certifier	· H.		29c. Lice	nse number		d. Date signed (Month,	
7/		Vina Go	4117		D4:	1162	F	ebruary 14,	2005
V		30. Name and address of person who	completed cause of de	ath (Item 23a) (Typ	e, Print)				
		Vinu Ganti, M.D.	19529 Do	ctor's Dr	rive, Ger	mantown,	MD 20874		
S Regis	tate trar	31. Date filed (Month, Day, Year)	2005 32. Figistrai	r's Signatur	Goods				

			For State		State of M	Marylan	•	artme			and Me	ental Hy		2000	ī (173	1. 1
			Registrer 1. Decedent's Name (First,	Middle Las	st)			Timoa		Journ	- 1	2. Date of De	Reg. No		3.	. Time of	Death
П	Physici	an	110	1		ens						Month O 2	Da OZ	200		-40	Рм
	/Medic		4a. Facility Name (If not ins	titution six			-	4h Cih	Town or	Location o	of Death	02	1	County of D		17	-
	Examin	er		1 1 1 1							Dout				Jan		
			HOWARD COUN 5. Social Security Number	TY GE		Age (In yrs.		-	UMBIA or 1 Year	If Under:	24 Hrs.	B. Date of Bi		OWARD	Birtholace	(State or	Foreign
4	Funeral Director		214-07-7789		☐M 2 X F	89	Yrs.	Months		Hours	Min.	(Month, D	ay, Year)		Country)		. or olgri
			Usual Residence of Decede	ent		09		1			12	SEPT.	19,	1913	MARYI	LAND	
	iand ow		10a. State 10b. C			10c. Cit	y, Town or I	ocation							10d.	Inside Cit	y Limits
	Mary feb	ō	MD HO	WARD		COL	UMBIA									1 🗌 Yes	2 🗶 No
	288 288	Director	10e. Street and Number	MAILU		COL	OFIDIA	10f. Z	p Code				10g. Cit	izen of What	Country?		
	with with		ELOO WANTAC	E DOT	TT DOAD			2	1044				US.	A			
	leath	Funerai	5400 VANTAG	E PUII	12. Was Decede	nt Ever in U	.S. 13	Was Dec	edent of Hi	spanic Orig	gin? (Spec	ify Yes or No		14. Race - A	merican I	ndian,	
	fter of the r	ᆵ	1 Never Married 2	Married	Armed Force 1 ☐ Yes 2			. ,	_		, Puerto R	ican, etc.)		Black, W			
8	urs a	þ	3 Widowed 4 □ Div	orced	If Yes, Give Year or Date:	s:		1 🗌 Yes	2 X No	Specify:				Specify:	WHIT	E	
Ģ	72 hours after death with the Maryland natural; or tterne 23a or 28a-f ehow disal Examinat must be notified at	ted	15. De	cedent's Ed	lucation		16a. Dec	edent's Us	al Occupa	ition	t of conditor		16b. K	ind of Busine	ss/Industi	гу	
7	within 7. ene. then "n	pie	(Specify only Elementary/Secondary (0		de completed) College (1-4c	(r.5±)	life.	DO NOT	ork done d use retired	i uring mosi }	of working	9					
212	d with	Completed	12	12/	1		ADM	NIST	RATOR				CI	VIL SE	RVICI	Ε	
b	be filed within 72 hours after death with the Marylan ital Hygliene. Id other then "naturel", or itema 23a or 28a-1 ehow event, the Medical Examinar must be notified at	a)	17. Father's Name (First, M	iddle, Last)						18. Mothe	r's Name (First, Middle	, Maiden	Sumame)			
<u>a</u>	ld be lenta kad ic e	To B	EDWARD LOWE							JERU	SHA E	IURLEY					
Maryland 21215-0036	s 1 and 2 should be t Health and Mental item 27 is marked o other traumatic eva		19a. Informant's Name/Rei	ationship (7	Type, Print)		19b. Mai	ing Addres	s (Street a	ind Numbe	r or Rural	Route Numb	er, City o	r Town, State	, Zip Coc	de)	
Š	d 2 th		THOMAS BART	HOLOM	EW/SON-IN	-LAW	4948	FOX	GRAPI	E TER	RACE,	COLUN	ŒΙΑ,	MD 2	1044		
re,	is 1 and 2 of Health a item 27 is othar trau		20a. Method of Disposition			20b. P	lace of Disp	osition (Na	ime of	2)	Da	te	20c. Lo	cation - City	or Town,	State	
2	ant of		1 🔣 Burial 2 □ Crem '4 □ Donation 5 □ Ot			te SHĂ	RPTOW	S FI	REMAN	S o	2/13/	2005	CH/	ARPTOW	ı mr)	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 ony injury or other once.		21. Signature of Funeral Se			LEF	ETERY	2. Name a	nd Addres	s of Facilit	V						
Ba	Department of the population o		1/1/01	X1	31/	_	F	ELLOW	S HEI	FENB	EIN &	NEWNA HESTER	MFI	NERAL 2161	HOME	, P.	A.
			23a. Part1. Enter the disea	Se or com	dications that caus	ed the deat								2101	1	proximate	
			shock, or heart failure	List only	opé cause on each	line.							_	. \	Inte	erval Betw set and D	reen
	Physician		Immediate Cause (Final disease or condition resulting in death)	_	a Athe	VUSC	clero	tic o	Corro	MOV	asc	ula:	r 1)	iseas	e_		
	/Medical Examiner		resulting in death)		Due to (or a	as a conseq	uence of):										
ш	Examine	_	Sequentially list conditions		b												
	slt sd	Examiner	if any, leading to immediate cause. Enter Underlying	' ~	Due to (or a	as a conseq	uence or):										
	and tran	cam	Cause (Disease or injury that initiated events resulting in death) Last		C. Due to (or	as a conseq	uonoo of):									<u> </u>	
0	be executed sician and burial-transit				Due to (or a	as a conseq	derice or,										
8760,	cate be executed physician and the burial-transIt	dicai		•	d										-	-	
9	ing p	Mec	IF FEMALE:												1		
Вох	death certific attending p	an/	23b. Was decedent pregna in the past 12 months	trit .	23c. If yes, outcon 1 ☐ Live birth			□Ectopic i	pregnancy					23d. Date of o Month	delivery Day	· Y	ear
	the at	sici	1 ☐ Yes 2 🔁 No		4□Pregnant 9□Unknown		eath 5	Other (s	pecify)						,		
P.0	by tac	Physician/Me	9 Unknown														
	es the	by	Part II. Other significant co	anditions co	ontributing to death	but not res	ulting in the	underlying	cause give	n in Part I.				ise contribute			
Vital Records	w requir been si should	ted										1	Yes 2	□No 3□	Probably	4 (35 (U)	IKHOWH
S	e law re has be je 2 sh	Completed										24a. Was		24b. Were	autopsy f	findings a tion of ca	vailable
ď	0 5 0	E O										perfo	ormed?	death			
ta	iclan: Th certificate rector, pag	a	25. Was case referred to m	nedical						26. Place	of Death (Check only					
>		To B	examiner? 1 ☐ Yes 2 No		Hospital:	itient 2 🗆	ER/Outpatie	nt 3□□	OA Othe	1E 4 □ Nu	rsing Home	e 5 🗆 Resi	idence	6 □Other (S	pecify)		
of	g Phys er this eral di		27. Manner of Death		28a. Date of Ir	njury Da <i>y</i> Yea <i>r)</i>	28b. Time Injury	of	28c. Injury Work	at	28	d. Describe	how injur	y occurred			
ion	nding lth. :: After e funer	atio		Pending nvestigation		say rour,	пцагу	М		res 2 □ t	No						
Division	if or Attending after death. Director: After d in by the fune	Certification:		Could not be determined	280. Place of	Injury - At ho	ome, farm, s	treet, facto	ry, office		28	f. Location (City or To	Street an	d Number or	Rural Ro	ute Numb	er,
Ö	afor A	ert	4 LI Homicide		building,	etc. (Specif	Y)					Only of 10	wii, State	/			
	Hospital	aic			ysician: To the be												
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	edical	(Check only 2 Me	dical Exam	niner: On the basis and manner	of examina stated.	tion and/or i	nvestigatio	n, in my op	inion, deat	n occurred	d at the time,	date and	l place, and d	ue to the	cause(s)	
	onthir routh	Me	29b. Signature and title of	ertifier				-	c. License				29d. Dat	e signed (Mo	nth, Day,	Year)	
}	. , , , ,		1	10				17)42	725	pro-		2	1041	05		
		ŀ	30. Name and address of p	erson who	completed cause of	f death (Item	1 23a) (Type										
1	CI		TARIO N	104	moop 32. Reging	201-11	09 R	ack	Riv	es N	reck	Rd	130	time	re		
1	Sta	te	31. Date filed (Month, Day	Year) .	1 20 n 32. Regi	ar's Signa	ture	4									
	Registr	9 14	Fi	TR T .	T ZOND	Moure	· H.	dos	the								

Amend Item 26 per State of Maryland / Department of Health and Mental Hygiene 0 5 07362 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** February 19, 2005 Frederick Taylor Powell 12:15 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Goodwill Mennonite Home Grantsville Garrett If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 030-01-9609 17, 1920 Director 84 Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. nt: If item 27 is marked other then "neturel", or items 23e or 28e-f ahow 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits item 27 is marked other then "neturel", or items 23e or 28e-f ahow other treumatic event, the Medical Examiner must be notified at MA Barnstable Chatham 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 257 Stage Harbor Road 02633 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 10/11/45 1□ Yes 2⊠No Specify: 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0020 Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Commercial Fisherman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Powell Rosalie Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick T. Powell, Jr/son 42 Linden St., Frostburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 X Cremation 3 □ Removal from State mportant: If Injury or 4 ☐ Donation 5 ☐ Other (Specify) Country Side Crem. Feb 20, 2005 Davidsville, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility an's Newman Funeral Homes, P.A., PO Box 275 Human 179 Miller St., Grantsville, MD 21536 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner arte or Attending Physician: The law requires that the death certificate be executed ettending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause are or the cause of th # H P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 百 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ◯ Unknown signed Completed by Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? peen has 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) ဠ 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date-signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 Miller St., Grantsville, MD 21536 Robin Bissell, M.D., 32. Registrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death y 16, 2005 Physician Month February 5:05p M Raymond J. Purnell /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing and Rehabilitation Ctrl. Worcester 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2 □ F Director 212-05-7020 MD Aug. 11,1918 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or items 23e or 28a-f show the Medical Exeminar must be notified at 1 Yes 2 No Director Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Newport Dr. US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Clergy Church Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fund Mental I Keral Allmon Purnell Blanche S. Lawson or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Newport Dr., Ocean Pines, Md. 21811 Helen Jones Purnell (wife) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ★Burial 2 Cremation 3 Removal from State permit. Pag Department Importent: I any injury o Gardens of the Pines 2-19-05 * 4 ☐ Donation 5 ☐ Other (Specify) Ocean Pines, Md. 21. Signature of Suneral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 23a. Parti. Enter he risease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, phoch or heart failure. List only one cause peach line. 108 William St., Berlin, Md. 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovasialar heroscheretic **Physician** cers /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 Yes 2 No Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No 27. Manner of D ath Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1. ZNatural 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: / Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my points. 29a, Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel ٥ 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) 105 0 completed cause of death (Item 23a) (Type, Print) nd address of perser Nicholas delies 31. Date filed (Month. 32 Registrar's Signature State Registrar

Raymond

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 19-e011 larian -ebruary 200 /Medical 4a. Facility Name (If not institution, give street and number) to. City, Town, or Location of Death 4c. County of Death Examiner [-lizabeth ursina 50 timore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | May 23, 5. Social Security Number 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 7. Age (In yrs. last birthday) 143-12-4495 1 □ M 2 🕅 F 82 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f ehow interment by notified at Director 1 ☐ Yes 2 No MD Prince Georges' Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23e 11204 Laurel Grove Court 20708 death Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. unt: If Item 27 Is marked other then "naturel", or ite Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Impurelt, on Importent: If Item 27 is marked other then "naturelt, on any injury or other treumatic event, the Mudical Exampnes. 1 ☐ Yes 2 🕅 No by Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sam DeMarco 2 Rosaria Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Green/ Daughter 11204 Laurel Grove Court, Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State February Greenwich Twp., NJ `4 □Donation 5 NOther (Specify)Entombment Holy Apostles 18, 2005 22. Name and Address of Facility DeVol Funeral Home, 10 Deer Park Drive, Gaithersburg, MD 20877 21. Signature of Funeral Service Lice see IRACU TUU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician emen Vears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Jeseas or injury that initiated events Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as 1 IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy for Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? rena insut nronic 1 ☐ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2.2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 P.O. Division of Vital Records, Hospitel or Attending Physicien: within 24 hours after deat To the Funeral Director: completely filled in by the

> 332 enson 31. Date fil (M. nth, Day, Year) 7 2005 Registrar

30. Name and address of person who complete Jeause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

Avenue

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

l-tbruary 15, 2005

Baltimore

	1 - For State Registrar	State of Maryland / Dep Ce	ertment of Health and I	Mental Hygie	2005 07015
Physicia	FILMUOSE CITZA			2, Date of Death Month	Day Year 3. Time of Death
/Medica Examine	al	e street and number)	4b. City, Town, or Location of Death Gaithersburg	February	15 2005 5:38 P N 4c. County of Death Montgomery
Funeral Director	5. Social Security Number 6. S 215-50-8823	ex 7. Age (In yrs. last birthday M 2 4 F 91 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye) July 28,	9. Birthplace (State or Foreig
be filed within 72 hours after deeth v lal Hygiene. d other then "natural", or Items 23s event, the Medical Examinations.	10a. State 10b. County	nue #313 12. Was Decedent Ever in U.S. Armed Forces? 1	was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto I Tyes 2 No Specify: adent's Usual Occupation a kind of work done during most of work DO NOT use retired) emaker 18. Mother's Nam Jane F ing Address (Street and Number or Ru Dyal Oak Court Ro	Date Un Decity Yes or No- De	omew y or Town, State, Zip Code) Maryland 20854 Location - City or Town, State Lexandria, Virginia
Physician /Medical Examiner and the prival-transit the prival-transit	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Obsasse or Injury that initiated events resulting in death) Last	plications that caused the death. Do not er			Approximate Interval Between Onset and Death
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sician: The law southineter, page 2 s	Hyperlipidemia; Coronary Artery			24a. Was an autopsy performed? 1 ☐ Yes 2 🔯 N	
tending Phy leath. tor: After this the funeral o	25. Was case referred to medical examiner? 1		Other: 4 Nursing Ho 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred and Number or Rural Route Number.
To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	29a. Certifier 1 X Certifying Ph	ysicien: To the best of my knowledge, dear niner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, ivestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)
To within	29b. Signature and title of certifier / f. Raccutt,	Birehlagus			ebruary 16, 2005
State	H. Robert Birsch	32 Registrar's Signature	sell Avenue Gaitl	nersburg, l	Maryland 20877

DHMH 17 Rev 1/2001

			1- For State of Maryland / De Registrar	epartment of He Certificate of D		ntal Hygier	2005	07346
ı	Physici		1. Decedent's Name (First, Middle, Last) Betty Ellen Palmer			Date of Death Month Druery 13	2005 Year	3. Time of Death 11 55 _M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Calvert Mexorial Hospital	4b. City, Town, or L Prince Fred	ocation of Death	-	tc. County of Death	n
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ 7. Age (In yrs. last birth 67 Yr	Months Days	Hours Min.	Date of Birth (Month, Day, Yea Ly 22 1937		hplace (State or Foreign untry) E
	Maryland f ehow	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Calvert Prince F	r Location rederick				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the Pie or 28e-	Direct	10e. Street and Number 2305 Grays Road	10f. Zip Code 20678			Citizen of What Co	untry?
036	be filed within 72 hours after death with the Maryland that Hygiene. So of ther then "netural", or items 23e or 28e-f ehow event, the Medical Evaluation must be redified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specif Mexican, Puerto Ric Specify:		14. Race - Amer Black, White Specify: White	rican Indian, e, etc.
21215-0036	filed within 72 hor Hygiene. kher then "neturi int, the wedical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupati Give kind of work done dur ife. DO NOT use retired) or clerk	ion ring most of working		Kind of Business/l	
	ould be filed a Mental Hygie arked other atic event, the	Be	17. Father's Name (First, Middle, Last) Franklin Hallowell		8. Mother's Name (F	irst, Middle, Maide		2
Maryland	2 sh and le m	J.	19a. Informant's Name/Relationship (Type, Print) 19b. !	Mailing Address (Street and Grays Road Pri	nd Number or Rural F	loute Number, City		ip Code)
Baltimore,	Pages 1 and Pealth of Health of Health of: If item 27 y or other tr		20a. Method of Disposition 1 20b. Place of I commetery. 20b. Place of I commetery.	hisposition (Name of crematory or other place)	Date	20c.	Location - City or 1	
Baltii	perril. Pages: Deportment of H Importent: If ite any njury or ot		21. Signature of Funeral Service Licensee	22. Name and Address	of Facility Rausch	Funeral H	me	
	Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. (In a shock) a.	4405 Brooms Is t enter the mode of dying, eart fail	such as cardiac or re	espiratory arrest,	aryland 20	proximate Interval Between Onset and Death
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09289	ifficate be g physici as the bu	edicai	a Peripheral vas	cular disea	isc			years
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	v requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the Aspiration preumonia Pulmonary embolism	te underlying cause given	in Part I.	/		the cause of death?
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	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	Other	26. Place of Death (C 4 ☐ Nursing Home		6 □Other (Spec	ify)
Division of	ling After une		27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	iry Work?	at 28d	. Describe how inj	ury occurred	
Divi	itel or Attenors after deathel Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f.	Location (Street a City or Town, Sta	and Number or Rui ite)	al Route Number,
	To the Hospitel or within 24 hours aft To the Funerel Discompletely filled in	ledical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, (Check only one) 1 Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my opin	nion, death occurred	at the time, date a	nd place, and due	to the cause(s)
)	To With	M	29b. Signature and title of certifier Haspitalian, Haspitalian, mo	29c. License n	90	2	late signed (Month,	05
	10		30. Name and address of person who completed cause of death (Item 23a) (The ADEB JABER 100 H357 TA 31. Date filed (Month, Day, Year) 32. Registrates Signature FEB 1 7 2005	pe, Print) L Ro. Pr.	ince free	DENICK,	MO 21	0679
	Sta Registi	-	31. Date filed (Month, Day, Year) 32. Registra's Signature FEB 1 7 2005	4 Sparks	,0			

			For State Registrar	State of Maryland		artment of F		, ,	ene g. Ng? A A S	07017
			Decedent's Name (First, Middle,	Last)				2. Date of Death	The best of the same	3. Time of Death
	Physici		LOUISE	BROOKHART	PU	TNAM		FER 3	75 200	5 1:35 M
}	/Medid Examin		4a. Facility Name (If not institution, g				r Location of Death		4c. County of De	
			MARINER HE	ALTH-BELAIR	2	BEL	AIR		HARFE	OR /
	Funeral			Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	hirthplace (State or Foreign Country)
	Director		214-34-2948	87	Yrs.			11/1/1		<u>Maryland</u>
	and mand		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limits
	Mary f sho	jo	MD. Har:	ford		Bel	Air			1 ☐ Yes 2 No
	r 28a	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	h witt	a D	144 Hickory	Avenue			21014		Unite	d States
	ams str	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces2	. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Ar Black, Wi	nerican Indian,
36	be filed within 72 hours after death with the Maryland hat Hygiene. dd other than "natural", or Itams 23a or 28a-1 show event, the Medical Examinat must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 No	Specify:			
21215-0036	houn tural	d b		Year or Dates:	160 Door	dont's Usual Occur	ation .			White
5	in 72 na r	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	6b. Kind of Busines	ss/industry
7	with jiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Cle	rk		Grocer	y Store
	be filed ital Hygi id other event, I	BeC	17. Father's Name (First, Middle, La	ist)				e (First, Middle, M		y 5010
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lan)	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ins Ma		19a. Informant's Name/Relationship						City or Town, State	Zip Code) 21084
≥,	and ealth m 27		Elaine Putnam			42 Saler	n Churc			tsville,Md.
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	netery, cre	osition (Name of matory or other plac	'		0c. Location - City	
Ħ,	tment tant:		' 4 □ Donation 5 □ Other (Spe			ille Cer	n. 2/28,	$/2005 J_{1}$	arretts	ville, Md.
Bai	Departition Departition Departition Departition Departition Department of the Depart		21. Signature of Funeral Service Liv	ientee // //		2. Name and Addre	0	arretts	ville, 1	Maryland
	45244		222 Part 1 Enter the disease or or	omplications that caused the death.					ral Home	e. P.A.
			shock, or heart failure. List or	nly one cause on each line		,	ig, such as cardiac	or respiratory arres	51,	Interval Between
	Pnysician /Medical		disease or condition resulting in death)			mla				bauys
	Examiner			Due to (or as a conseque	ence of):					/
	1.000	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	nce of):					
	cuted id ansit	Examiner	cause. Enter Underlying that initiated events	6						
o,	an an rial-tr	Exa	resulting in death) Last	Due to (or as a conseque	ince of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		d						
9	n certifica anding pl use as t	Med	JF FEMALE:		-					
Вох	eath certifii attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal d	leath 3[Ectopic pregnancy	,		23d. Date of d Month	elivery Day Year
P.O.	the a	ysic	1 ☐ Yes 2 € No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ith 5	Other (specify)				ouy .ou.
۵.	that the de ned by the a detached t	h.	Part II. Other significant conditions	s contributing to death but not result	ing in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ds,	uires tha signed Id be del	Completed by	Chrunic Obstr	wetive Pulmo		4 218	0051	1 ▼ Yes		Probably 4 Unknown
COL	w requir been si should	iete			/			24a. Was an	24h Wara	autopsy findings available
Re	he lav e has age 2	m C						autopsy perform	ed? prior to death?	completion of cause of
Vital Record	vician: The lav certificate has rector, page 2	0	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes 2 th (Check only one)	No 1 LY	es 2 No
	Physician: r this certificaral director,	To B	examiner? 1 Yes 2 No	Hospital:	R/Outpatier	nt 3 DOA Oth	Tara .		ce 6 □Other (Sp	pecify)
Division of	ding Phys h. After this funeral di		27. Manner of De Ih	28a. Date of Injury 2 (Month, Day Year)	8b. Time o	f 28c. injur	y at	28d. Describe how		
<u>0</u>	ttendir death. ctor: Af y the fu	Certification:	1 Vatural 5 Pending 2 Accident investigat	tion	, ,		Yes 2 □ No			
ž	l or Atteno after death Director:	ij	3 Suicide 6 Could not determine		ie, farm, sti	eet, factory, office		28f. Location (Stree City or Town,	et and Number or I State)	Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page									
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my knowle maniner: On the basis of examination	ledge, deat on and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner a e and place, and di	as stated. ue to the cause(s)
	o the ithin ; o the omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	e number	290	d. Date signed (Mor	nth, Dav. Year)
)	⊢≯⊢ŏ		· NIL 1	クク						
,	1		30. Name indiaddress of person wh	no completed gause of death (Item 2	23a) (Tyne	Print)	6)		Druguy	~, ~~)
	2	1	Scott Hai	well a No	v.th	Avenu	1 31)	Air M	iny June	1 2/014
	Sta	ite	31. Date filed (Month, Day, Year)	32. Paistrar's Signatur	re					
	Registi	ar	MAR. 0 4	2005 Kenton L	X B	28082				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death Day 21, 2005 Month **Physician** February 3:00am Raymond L. Preston /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a. Facility Name (If not institution, give street end number) Examiner Sunbridge Care Nursing Home Elkton Cecil If Under 1 Year | if Under 24 Hrs. 9. Birthplace (State or Foreign Country) 19,1923 MD 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) **Funeral** 1∏M 2□ F Months Days Hours Min. Yrs. Director 219-12-9227 81 November Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🎎 📆 No by Funeral Director Cecil Elkton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21921 16 Clear Creek Glen U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. k⊟vYes 2 □ No fYes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 9 Customer Service Southern States 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ۵ William L. Preston Mary Louise Potts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Halsey/Daughter 16 Clear Creek Glen, Elkton, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date February Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cherry Hill Methodist24,2005 Elkton, MD CemeterayName and Address of Facility 21. Signature of Funeral Service Licensee Andrew G. Gee Funeral Home 259 East Main St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of): Examiner neumonia or Attending Physician: Tha law requiras that the deeth certificate be executed detached for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Division of Vital Records, P.O. Box 68760, cree Physician/Medical Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No þ To the Hospital or Attending Physician: Tha law requiras t within 24 bours after death.

To the Funeral Director, After this certificate has been signs completaly filled in by the funeral director, page 2 should be 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Be Completed 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury et Work? 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2/24/05 Frui chil Ivan D04823 30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) 223 Streat, W HSU wman Dr. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Sporte Registrar MAR 0.3 2005

DHMH 16 Rev 6/95

			amend unpe		Oldio of Mic		ertificate of		las	g. No.	1045
	Physici	an	Decedent's Name (')				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If n	EDWARD	IRVIN street and number)	PATCH		or Location of Death	February	4c. County of Death	9:05 P M
	Lxamiii	C)			al Medica	1 Center		sbury		Wicom	
107	Funeral Director		5. Social Security Num 220-52-08 Usual Residence of D	885 1È	KM 2FF	e (In yrs. last birthd 5	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7 – 9 – 49		place (State or Foreig intry) Md
	iryland show	_	10a. State 1	10b. County		10c. City, Town o					10d. Inside City Limits
	the Ma 28a-f s	ecto	Md .	Worcest	er	0cea	n City			2111	1. Yes 2 No
	3a or	i D	1932 Mai		ive		10f. Zip Code 2 1	842	10	g. Citizen of What Cou USA	intry?
9	after death or Items 2	/ Funeral Director	11. Marital Status		12. Was Decedent I Armed Forces? 1 Yes 252N		3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
-003	hours turel',	ed by	3 Widowed 4	15. Decedent's Edu	Year or Dates:	162 Do	cedent's Usual Occup				
21215	s filed within 72 hours after death with the Maryland Il Hygiene. other then "naturel", or Items 23a or 28a-f show vent, the Medical Examinar must be notified at	Completed		y only highest grad		(G lif	ive kind of work done e. DO NOT use retire	during most of workit	ng	onstruct	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Importent: If Item 27 le marked other eny injury or other traumatic event, 1000.	To Be		d I. Pa	tchett,				en Kirw	in	
Mar	od 2 sh lth and 27 le m		19a. Informant's Nam	,	,	123	2002			City or Town, State, Zi	
Je,	of Hea of Hea of Heam		Michael 20a. Method of Dispos	osition		20b. Place of Di	EOX 113: sposition (Name of crematory or other pla		ate 2	Md . , 2184 0c. Location - City or T	0wn, State
Baltimore,	Page tment tent: If		' 4 □ Donation 5	5 ☐ Other (Specify)		1	ury Crema	atory 2	-21 S	alisbury	Md.
Ba	permil Depar Impor eny in		21. Signature of Fun-	M AN Service Licens			22. Name and Addre	ess of Facility Funeral I	Home B	erlin, Mo	4
	Pnysician	17	23a. Part1. Enter the shock, or heart! Immediate Cause (Fidisease or condition resulting in death)	inal		Ourara	enter the mode of dying arrhythm cicular sc	na apport	r respiratory arres	st.	Approximate Interval Between Onset and Death
	/Medical Examiner					a consequence of):					
	sit ad	iner	Sequentially list cond if any, leading to inition cause. Enter Underly Cause (Disease or inj	ditions, frediate ying	b. — Due to (or as a	a consequence of).					
,	executed n and al-transit	Examin	that initiated events resulting in death) Las		c. Due to (or as	a consequence of);					
0	sicie				d						
376	# 5.C						-				
× 6876	ding physe as th	/Mec	IF FEMALE:		23c If yes outcome	of pregnancy				23d. Date of deliv	
.O. Box 68760,	the death certificate be exe by the attending physicien ar ached for use as the burial-t	hysician/Mec	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 1 9 Unknown	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnanc; 5 □ Other (specify) _	у		Month	ery Day Year
P.O.	equires that the death certifical ien signed by the attending phy ould be detached for use as th	ted by Physician/Medical	23b. Was decedent p in the past 12 m 1 \(\sum \text{Yes} \) 2 \(\sum \text{I}\)	nonths?	1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death time of death	5 Other (specify)			Month	Day Year
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P.O.	raicien: The law requires that the death certifical scertificate has been signed by the attending phy lirector, page 2 should be detached for use as th	Be Completed by	23b. Was decedent p in the past 12 m 1 □ Yes 2 □ t 9 □ Unknown Part II. Other significat 25. Was case referred examiner?	ocant conditions co	1 □ Live birth 4 □ Pregnant at 9 □ Unknown Intributing to death but	2 Fetal death time of death	5 Other (specify)	ven in Part I.	1 Yes 24a. Was an autopsy performe 15 Yes 2 (Check only one)	Month 2 No 3 Prol 24b. Were aut prior to co death? 1 Pos	Day Year the cause of death? pably 4 EUnknown posy findings available impletion of cause of 2 \(\text{No} \)
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		1- For State of Maryland /	Department of I		lental Hygie	- ZUII!	07350
Division.		Decedent's Name (First, Middle, Last)			2. Date of Death	_	3. Time of Death
Physic /Medi		ARLENE BRANNIGAN	ROSS		Month FEBRUARY	Day Yea 14 2005	10:25A M
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Death		4c. County of De	eath
		600 E. KNOLL CREST PLACE		CKEYSVILL	E	BALTIM	
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 59 Usual Residence of Decedent	irthday) If Under 1 Year Yrs. Months Days		8. Date of Birth (Month, Day, Ye NOV • 8 •	9. E 1945 NE	Birthplace (State or Foreign Country) EW YORK
/land		10a. State 10b. County 10c. City, Tow	vn or Location				10d. Inside City Limits
Man Illed	ţō	MD BALTIMORE	COCKEY	SVILLE			1 ☐ Yes 2√ No
th the	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What	Country?
23a (600 E. KNOLL CREST PLACE		21031		USA	1
be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "netural", or items 23a or 28a-f ehow event, the Madical Exatt national be invitibed at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates;	13. Was Decedent of If Yes, specify Cut		ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	
72 hours af netural', or	ed t	A	a. Decedent's Usual Occu		166		WHITE
in 72	Completed	(Specify only highest grade completed)	(Give kind of work done life. DO NOT use retire	during most of work	ing	o. Kind of Busines	ss/industry
d with giene ar tha	E O		ADMINISTRATI	VE ASSIST	ANT	REAL E	STATE
be filed vital Hygie of other tevent, III	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Mai	den Sumame)	
should be nd Menta marked imetic ev	To	SEYMOUR THAL		MARCIA		WEINS	TEIN
2 sho	. 10		b. Mailing Address (Street	and Number or Rura	al Route Number, Ci	ity or Town, State	, Zip Code)
and lealth m 27			7831 HAMPDEN	-	THESDA, M		
permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marken any injury or other treumetic once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of ary, crematory or other pla	ce)		. Location - City of	or Town, State
permit. Pages 1 ar Department of Hea Importent: If item any njury or other once.		'4 ☐Donation 5 ☐Other (Specify) 21. Signature of Syngral Service Literature	N MEMORIAL (22. Name and Addre		2-16-05	OLNEY, N	MARYLAND
		23a. Part 1. Effer the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dyi	ALDI FUNE HAMPSHIR ng, such as cardiac c	RAL HOME, E AVE. SI or respiratory arrest,	INC. LVER SPR	ING MD 2090 Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death) CARDIAC ARRES					
Examiner		WADTCEAT DIE	•				2 MONTHS
	je.	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury PRIMARY BILL)					Z MONING
cuted nd ransit	Examin	that initiated events	ARY CIRRHOSI	.s			3 YEARS
cate be executed physician and the burial-transit	dicai Ex	resulting in death) Last Due to (or as a consequence	of):				
	ledi						
at the death certifi by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of d Month	elivery Day Year
he law requires that the e has been signed by th ige 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting i OSTEOPOROSIS	n the underlying cause gr	ven in Part I.	23e. Did tobacc		to the cause of death?
	ojet	RIGHT AVASCULAR NECROSIS OF FEM	UR		24a. Was an	24b. Were a	autopsy findings available
T page	e Completed	HISTORY OF DEEP VEIN THROMBOSIS 25. Was case referred to medical			autopsy performed 1 ☐ Yes 2 🔀	? prior to death?	completion of cause of
ing Phy After this funeral d	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou 27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury	y at 2	ne 5 XResidence		ecify)
p afficient	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	2	28f. Location (Street City or Town, St	and Number or F ate)	Rural Route Number,
To the Hospitel within 24 hours a VTo the Funerel Completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	e, death occurred at the tind/or investigation, in my o	me, date and place, a pinion, death occurre	and due to the cause and at the time, date a	e(s) and manner a and place, and du	as stated. ue to the cause(s)
To t To t	E	29b. Signature and title of certifier	29c. Licens			Date signed (Mor	
5		· Collin, mo	DO	105662	3	02/15,	12005
		30. Name and a less of person who completed cause of death (Item 23a) Tin Gu, WD 7505 Osle	+ Dr. Suit	e 403 T	OWSCON	MD	21204
Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature FEB 1 7 2005	Sparle				

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Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar		Maryland / Do	epartmer Certificat	t of H	lealth a	and M		giene ()	05	073	52
ı	Physici		Decedent's Name (First, Middle Robert C. Reber	, Last)						2. Date of De. Month Feb 18 2		Year	3. Time of t	Death M
	/Medic Examin		4a. Facility Name (If not institution	, give street and num	ber)	4b. City,	Town, or	Location of	of Death			nty of Death	1	
	LAGIIII	C1	Calvert Memorial					derick			Calve			
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. last birth		r 1 Year	If Under Hours		8. Date of Bir	th v Year)	9. Birth	place (State or	Foreign
	Director		203 09 8218	1₩ 2□F	88 Yı	s. Worths	Days	Hours	IVIII I.	8. Date of Bird (Month, Da Nov 3 19	16		ylvania	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City	v Limits
	Maryl f sho	ō	Maryland Calvert		Solarans								1 🗌 Yes	
	r 28a	rec	10e. Street and Number			10f. Zij	Code				10g. Citizen o	of What Cou	ntry?	
	h with	a D	11750 Asbury Circle	e AL 100		2	0688				United	States		
	ems a	Funeral Director	11. Marital Status	12. Was Deced	dent Ever in U.S.	13. Was Dece	dent of H	ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	- 14. R	ace - Ameri lack, White,	can Indian,	
36	or it	y Fu	1 ☐ Never Married 2 ☑ Marri	ed 1 X Yes	2 No	1 ☐ Yes		Specify:	., , , ,			city: whit		
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show Jical Examinat must be mullied at	ed by	3 Widowed 4 Divorced	Year or Da	7 17 1 1 1									
5	in 72 in an " n	Completed	(Specify only highes	t grade completed)		lecedent's Usu Give kind of wo ife. DO NOT u	ai Occupi ork done d se retired	ation during mosi f)	t of work	ing	16b. Kind of	Business/ir	idustry	
212	d with giene.	mo.	Elementary/Secondary (0-12)	College (1-	40r 5+)	engineer					metallum	ന്നി	et col	
힏	al Hyg	Be C	17. Father's Name (First, Middle, I	Last)				18. Mothe	r's Name	(First, Middle,				
yla	Ment Ment arkec	ှု	Chauncey Reber				ļ	Emili	ia Cla	ark				
Maryland	12 shand and rism		19a. Informant's Name/Relations! Marcyaret: Reber – -w i							al Route Numbe			Code)	
e,	1 and Health em 27 ther t		20a. Method of Disposition	пе						Colorrons :	MD 20685 20c. Location		our State	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other treumatic event, it is Madical Examiliar and be recilified at once.		1 Burial 2 Cremation					1						
불	artme crtan injur		*4 □Donation 5 □ Other (S) 21. Signature of Funeral Service I		Metropol:	22. Name a			v		Alexandr	na Vin	jinia	
ñ	permit. Departr Imports any inju		BROW	100					Raus	sch Funer				
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the death. Do no	t enter the mod	ines I	g, such as	cardiac o	Republior respiratory ar	rest,	76	Approximate Interval Betw	
	Priysician	, e n	Immediate Cause (Final disease or condition		CARDIAL	TNE	AR	Dan					Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (d	or as a consequence of):							11100	(-)
	LAdillilei	<u>.</u>	Sequentially list conditions, if any, leading to immediate		COSCLEROT	IL CA	NOU	SUASE	ULA	n Di	SEADE		y May	
	ted	nine	cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a consequence of):								
,	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (c	or as a consequence of):								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	dical		d										
9	ntifical ng phi as th	a)	IS SERVALS.											
Вох	th ce tendi	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ome of pregnancy th 2 Petal death	3 □Ectopic p	regnancy				- 1	Date of delive	,	
	that the death certific ed by the attending p detached for use as	Physician/M	1 Yes 2 No	4□Pregna 9□ Unkno	int at time of death wn	5 Other (s	pecify)				P	Jonth	Day Ye	ear
P.0.	that the	Ph	Part II. Other significant condition	ns contributing to de	ath but not resulting in t	he underiving	ause oive	en in Part I		23e. Did to	obacco use co	ntribute to t	he cause of de	ath?
ds,	uires I sign Id be	d by	ULCERATIVE					D 11 0	_		/es 2 ⊡+No	/	oably 4 ∐Ur	
00	w requir been si should	lete								24a. Was	an 24t	. Were auto	psy findings a	vailable
Re	The lay te has age 2	Completed								autop perfo	rmed?	prior to co death?	impletion of ca	use of
tal	ician: The certificate rector, pag	0	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes Check onl o		1 🗆 Yes	2 No	
	Physic this ce al direc	To B	examiner? 1 Tes 2 No	Hospital: 1 🗆 In	patient 2 PER/Outp	atient 3 Do	Othe	er: 4 □ Nu	rsing Ho	me 5 Resid	dence 6 🗆 C	ther (Specif	(y)	
ם ם	Attending Physician: r death. ector: After this certifica by the funeral director.	on:	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date o (Month	f Injury 28b. Tir , Day Year) Inju	ne of	28c. Injury Work	at </td <td></td> <td>28d. Describe t</td> <td></td> <td></td> <td></td> <td></td>		28d. Describe t				
sio	Attendi death. ctor: A y the fu	cati	2 Accident investig	not be	d faire Albana fair	М		Yes 2 1		004	Throat and Alexandria		10	
Division of Vital Records,	l or Atten after deat Director: I in by the	Certification:	4 Homicide determine	ned 286. Place of buildin	of Injury - At home, fam g, etc. <i>(Specify)</i>	n, street, factor	y, office			28f. Location (S City or Tox		nber or Hura	al Houte Numb	e <i>r</i> ,
_	e Hospitel or 24 hours afte Funeral Dire etely filled in b		29a. Certifier 1 ☐ Certifyin	g Physician: To the	pest of my knowledge,	death occurred	at the tim	ne, date an	d place,	and due to the	cause(s) and r	manner as s	tated.	
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only 2 Medical I	Examiner: On the ba and mann	sis of examination and/	or investigation	, in my or	oinion, deat	th occurr	ed at the time,	date and place	e, and due to	o the cause(s)	
	To the within 2. To the I complet	Σ	29b. Signature and title of certifier	-1		29	c. License	number			29d. Date sigr	ned (Month,	Day, Year)	
}			(BL 4-	Wagel"	20)		02	635	8		FFB	18.0	2005	
4	+1		30. Name and address of person	who completed cause	or death (Item 23a) (The state of Registrate Signature	ype, Print)	FR	EDE!	RIC	t 1	17-1	267	8	
	Sta	-	31. Date filed (Month, Day, Year)	32. Re	gistra s Signature	4	ap.				./ X	`		
	Registr	ar	FEB	1 8 2005	Moren A	7. April	MARIE							

			For State Registrar		State of	Marylar		artmen rtificat			ınd M	ental Hyg	giene Reg. No.	005		735	53
I	Physici /Medi		1. Decedent's Nam Nadine G	e (First, Middle, L ertrude Ri	,							2. Date of Dea Month Feb 16 2	Day	Yea		3. Time of D	
	Examir			If not institution, g Emorial Ho	ive street and numb spital	oer)		4b. City, Prince		Location o	f Death			County of D	eath		
	Funeral Director		5. Social Security 028 20 3344		Sex 7	Age (In yrs. 76	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt July 29	1928			husetts	
	Maryland f show	or	Usuel Residence of 10a. State Maryland	10b. County Calvert		10c. Cit	ty, Town or Lo	ocation MCMS							10d	. Inside City	
	swith the 3a or 28a-	Funeral Director	10e. Street and Nu	sbury Circ	:le # 132			10f. Zip	Code 20688				•	zen of What			
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, tre Madical Examinar must be neilling at 2006.	þ	11. Marital Status	ried 2 Married	12. Was Deced	es? A No		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify: V	hite, etc		
21215-0036	filed within 72 h Hygiene. ither than "natu ant, ire Medica	Completed	(Spe Elementary/Sect 12t		Education trade completed) College (1-4	lor 5+)	16a. Deced (Give life.	kind of wo DO NOT u:	rk doné d	uring most	of workir	ng		nd of Busine and E.		•	enter
Maryland 2	12 should be filed within h and Mental Hygiene. 7 is marked other than " Iraumatic event, tre Mis	To Be C	17. Father's Name Joseph Nic	,	•					18. Mother		(First, Middle, ie Phill		Sumame)	-		-
	1 and 2 sho Health and Iem 27 is my		19a. Informant's N				ני 2070	lumer	Road			and 2065		r Town, Stati	e, Zip Co	ode)	
Baltimore,	Pages 1 ment of Hi ant: if iter ury or oth				□Removal from St	ate	Place of Dispo cemetery, crer ropolita	natory or o	ther place	Feb 1	7 200	ate 05		cation - City Padria V			
Balt	permit. Pag Department Important: I any injury o		21. Signature of F	uneral Service Lic	ensee C		0.00			s of Facility	ка	usch Fun Republi	93.				
	Physician /Medical		23a. Part1, Enter shock, or her Immediate Cause disease or condition resulting in death)	artfailure. List on (Final on	a	ised the deat th line.	h. Do not ent	er the mod	e of dying	A TO	cardiac or	respiratory and	rest,		A In O	pproximate terval Betwe nset and Dea	ath
	cate be executed by sician and the burial-transit and	Examiner	Sequentially list or if any, leading to in cause. Enter Undi Cause (Disease or that initiated event resulting in death)	onditions, nmediate erlying i injury s Last	b. A Ci Due to (or	as a consequence of a c	uence of):	CKR	000	c P)UL1	MONAR	4		-	Syris -11-	
		edicai E			d. P	OFU	10m	AIL							10	non	<u> </u>
.O. Box	The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	months?		h 2 ☐ Feta nt at time of d	I death 3	Ectopic pr Other (sp					2	23d. Date of o	delivery Da	ıy Yea	ar
rds, P	w requires that been signed b should be deta	by	Part II. Other signi	ficant conditions	contributing to dea	th but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	2.	se contribute No 3□	to the o		
		Completed										24a. Was a autop perfor	sy	24b. Were prior to death	?	findings ava letion of caus	allable se of
r Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case reference examiner?		Hospital:	patient 2	ER/Outpatien	t 3 D0	A Othe	r.		(Check only or		S []Other (S	pecify)		
vision	Attending ar death. ector: After by the funer	Certification: 7	27. Manner of Dea Natural 2 Accident 3 Suicide 4 Homicide	th 5 Pending investigati 6 Could not determine	on be 28e. Place o	Day Year)	28b. Time of Injury ome, farm, str	М		at	lo 2	8d. Describe h 8f. Location (S City or Tow	ow injury	occurred Number or		oute Numbe	r,
_	Hospital 4 hours a Funeral ely filled	edical Ce	29a. Certifier (Check only one)	S Certifying I	Physician: To the baseminer: On the base	is of examina	owledge, death	occurred vestigation,	at the time	e, date and inion, death	place, a	nd due to the d d at the time, d	ause(s)	and manner place, and d	as state	d. e cause(s)	
ì	To the within 2 To the complet	Mec	29b. Signature and		and manne	Soul	2_		. License			2	29d. Date	signed (Mo	onth, Day	y, Year)	5
	ID		30. Name and add	ress of person wh	o completed cause	of death (Iten	n 23a) (Type	Print)	Sta	303	Po	ince F	06	aruk	W	nost"	18
ſ	Sta	_	31. Date filed (Mor	nth, Day, Year)	7 2005 N	jistra s Signa	ure	NOW !		- 00-	111	ا کی در	NUL	nuy	L(I)	XVV.	! U

DHMH 17 Rev 1/2001

	ľ	For Stata Registrar	State of Ma	aryland		artment of H		nd Me	-	giene Reg. No.2	105	07351
Physicia		Decedent's Name (First, Middle Ina	, Last) Lee	Re	eed				2. Date of Dea	ath	2005	3.10 P M
/Medic Examin		4a. Facility Name (If not institution,	give street and number)	itai		4b. City, Town, or	Location of	Death	1	4c. Coun	ty of Death	W
Funeral Director		5. Social Security Number 217-28-8929	4 TH 9 FR	6 (In yrs. la 75	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birt (Month, Da Feb 1,	^h 1930	Count	ace (State or Foreigr ry) VV
Maryland f show	or	Usual Residence of Decedent 10a, State 10b, County MD Alleg	gany	10c. City	Town or Lo	perland					10	d. Inside City Limits
with the 3s or 28s	I Director	10e. Street and Number 111 Industrial B	lvd. W.		N -	10f. Zip Code	21502			10g. Citizen o	f What Count	ry?
urs after deatt	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? 1 Yes 2 If Yes, Give Year or Dates:		1	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No			cify Yes or No Rican, etc.)		ace - America ack, White, e	tc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Department of Heatile and Mental Hygiene. Department of Heatile and Mental Hygiene. By injury or other traumatic evant, I've Meulical Evaniner must be notified at once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	's Education t grade completed) College (1-4or 5		16a. Deced (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired maker	ation during most	of workin	g	16b. Kind of	Business/Ind	
uld be file Mental Hyg irked othe itic evant,	To Be C	17. Father's Name (First, Middle, L Theodore Sny							(First, Middle, Ullery S	Maiden Suma nyder	зте)	
and 2 sho salth and 1 n 27 is me		19a. Informant's Name/Relationsh Barbara Miller	nip (Type, Print) daug		324	ng Address (Street a 5 Evetts C		Road	Bedfo		n, State, Zip PA	^{Code)} 15522
Pages 1 ment of He ant: If itan ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp.	3 □Removal from State	Ce	metery, crer	esition (Name of matory or other place emorial Gar			3/2/2005	20c. Location		vn, State
permit. Depart Import any inj		21. Signature of Funeral Service L	icenser	U	. 22	2. Name and Addres Scarpell 108 Virg				land, ME	21502	
Physician /Medical Examiner		sbeck, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	Due to (or as	e. Geu7 a consequ	F M.	er the mode of dying						Approximate Interval Between Onset and Death DA1
cate be executed physician and streets the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as									
the death certific by the attending pached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)					Date of deliver Month I	y Day Year
quires that n signed b	by	Part II. Other significant condition	ns contributing to death b	ut not resu	iting in the u	nderlying cause give	en in Part I.		23e. Did to	- /		cause of death?
The law recate has bee	Completed								24a. Was autop perfo 1 \(\text{Yes} \)		prior to com death?	sy findings available pletion of eause of
Physician: this certific	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital:		Ryoutpatier		00		(Check only only only only only only only only	ne) ience 6 □O	ther (Specify,	
Livision of the Hospital or Attending Physician: The law requires that the death certification of the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ertification:	27. Manner of Death 1	pation not be	y Year) urv - At ho	28b. Time o Injury me, farm, str	Work	/at k? Yes 2 □ N	lo		Street and Nur. State)		Route Number,
Hospital 24 hours is Funeral stely filled	ledical Ce	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best Examiner: On the basis o and manner st	fexaminat	wledge, deat ion and/or in	h occurred at the tim vestigation, in my op	ne, date and pinion, death	place, a	nd due to the d at the time,	cause(s) and r date and place	manner as sta e, and due to	ited. the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	2	1	CLAN	29c. License	o number	44		29d. Date sign	ned (Month, D	1ay, Year) 2005
4	541	30. Name and address of person	///JOSE C	OVET	RIACU		SETUI	N Di	rivi c			1021502
Sta Regișt		31. Date filed (Month, Day, Vear) MAR 0 4			ture A							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	arylar				lealth a Death	and M		Reg. No.	005	073	55
	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of D	Day	Year	3. Time of	
	/Medio		DOROTHY JEAN RUD 4a. Facility Name (If not institution, given				4b. City	Town, or	Location of	of Death	FEBRUA		2005 inty of Death	2:25	P ^M
	LXAIIII	ICI	GARRETT COUNTY M		SPIT	'AL		KLANI					RETT		
	Funeral Director		219-34-1/46	- C CT -	e (In yrs. 19	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	B. Date of Bi (Month, D DEC 24	rth ay, Year) 1925	9. Birth Cou P	place (State or Intry)	r Foreign
	Maryland a-f show	tor	Usual Residence of Decedent	,		y, Town or Lo					<u></u>			10d. Inside Cit	
	or 28	Director	10e. Street and Number				10f. Zi	p Code				10g. Citizen	of What Cou	intry?	
	ath w	ral	107 S. NINTH STR	~				2155				USA			
920	urs after de al', or items mammer m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Dece If Yes, spe 1 ☐ Yes		spanic Origin, Mexican Specify:	gin? (Spo , Puerto	ecify Yes or No Rican, etc.)		Race - Amer Black, White ec <i>ify:</i> WH		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinational be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		5+)	16a. Dece (Give life. REGIS	kind of wo	ork done d ise retired	during most ')	of work	ing		f Business/li		
land 2	uld be filed Mental Hygir irked other itic event, II	To Be Co	17. Father's Name (First, Middle, Last EDWARD ATLEE M	ILLER							(First, Middle				
, Mary	and 2 should ealth and Men m 27 Is marke ser traumatic		19a. Informant's Name/Relationship (I. ROBERT RUDY -			121 N	. SE	COND		ET		per, City or To		ip Code)	
Baltimore,	00		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specil		C	Place of Dispo cemetery, crea RRETT 1	natory or	other place	1		24/05		on - City or T	own, State ARYLANI)
Bait	permit. Pag Department Important: h any injury o		21. Signature of Funegal Service Lice	met	M001				s of Facility	•	P.O. - OAKL	BOX 2		50	
	Physician and physician and physician and physician and physician and the physician and physician an	I Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. PNE	CUMON a conseq CHEIM a conseq	Uence of): ERS DE			g, such as	cardiac c	r respiratory a	rrest,	1	Approximate Interval Betwoonset and D	veen
.O. Box 68760	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Feta	Ideath 3□	Ectopic p Other (sp					23d.	Date of deliv	,	ear
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions of	contributing to death b	ut not res	ulting in the u	nderlying	cause give	on in Part I.			tobacco use c Yes 2 □ No		the cause of de	eath?
		Completed									24a. Was auto perfo 1 \(\text{Yes}		prior to co death?	opsy findings a ompletion of car	vailable use of
Z Z	iician: Th certificate rector, paç	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only				
on of	ding Ph h. After th funeral	ıtlon: To	1 Yes 2 No 27. Manner Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry	28b. Time of Injury		28c. Injury Work	4 🗀 1901	-	ne 5 🗌 Resi 28d. Describe			fy)	
DIVIS	tal or Attencrs after death	Certification:	3 Suicide 6 Could not b	e 28e. Place of Injubulding, etc			eet, factor	y, office		1	28f. Location (City or To	Street and Nu wn, State)	mber or Ruri	al Route Numb	er,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edical	(Check only ~2 Medical Exar	niner: On the basis of and manner sta	examina	wledge, death tion and/or inv	estigation/	, in my op	inion, deat	d place, a	and due to the ed at the time,	date and place	e, and due t	o the cause(s)	
	with To	Σ	29b. Signature and title of certifier	Johns	_		29	c. License	number 7	33	3	29d. Date sig	$\frac{1}{2}$ (/ (Day, Year)	
			30. Name and address of person who THOMAS G. JOHNSO			n 23a) (Type, N. FO		STRE	ET	OAKI	JAND, M	D 2155	0		
	Sta Registr		31. Date filed (Month, Day, Feb.)	2 3 2005 egistra	ar's Signa	ture	i de	serell.	S.						

	1- For Amend Item Registrar	State of Maryland 26 per Verb.	Department of L Certificate of	leaith and N 05dhb Death		2005	0735		
	1. Decedent's Name (First, Middle, Last)					Day Year	3. Time of Dear		
sician edical	MARK WESLEY S	WICK			FEB. 26	, 2005	6:45 P		
miner	4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, o	or Location of Death		4c. County of Dea			
	12221 WENDY LAN		WALD		0.00	CHAR			
eral	5. Social Security Number 6. Sex	7. Age (In yrs. la M 2□F	ist birthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ar) C	thplace (State or For ountry)		
tor	215-84-5278	44	113.		JULY 14	,1900 W	EST VIRG		
_	Usual Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Location				10d. Inside City Lin		
9	MADIA AND CHADT	E.C.	WALDORF				1 □ Yes 2 🔀		
other traumatic event, the Medical Examerer must be notified at To Be Completed by Funeral Director		MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code							
			11	S.A.					
era	12221 WENDY LANE	2. Was Decedent Ever in U.S	2 0 6 13. Was Decedent of I If Yes, specify Cub		ecify Yes or No-	14. Race - Am	erican Indian,		
Funeral	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2X No	If Yes, specify Cub		Hican, etc.)	Black, Whi	te, etc.		
by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 Yes ZLANO	Specify:		Specify: W	HITE		
t, the Medical I	15. Decedent's Educ (Specify only highest grade	ation completed	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work	sing 16t	. Kind of Business	/Industry		
Med ple	Elementary/Secondary (0-12)	College (1-4or 5+)							
# PO	12		HVAC SPECI			APRON C	OMPANY		
event Be (17. Father's Name (First, Middle, Last)				me (First, Middle, Maiden Sumame) : LEWIS				
To	ELWOOD SWICK								
Š.	19a. Informant's Name/Relationship (Typ		19b. Mailing Address (Stree						
er tr	LAURA A. SWICK		12221 WENDY			MARYLAN Location - City o			
fe	20a. Method of Disposition XCXBurial 2 Cremation 3 Re	1 00	ace of Disposition (Name of emetery, crematory or other pla		Date 200	:. Location - City of			
o fur	'4 □Donation 5 □Other (Specify)	TRINITY	MEMORIAL G	DNS \ 3-3	3-05 W	ALDORF,	MARYLAD		
any injury or other once.	21. Signature of Funeral Service License	M00479	RAYMOND		SERVICE	. РД			
# 8	Muchael	0. X	TA DIATA	MARVI	ND 206	46			
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deat								
cian	Immediate Cause (Final disease or condition PAT AVA) (BIT/FEY								
lical	resulting in death)	Due to (or as a consequ	uence of):				1		
iner	Sequentially list conditions								
ne r	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience of):						
ial-transit Examine	that initiated events								
E EX	resulting in death) Last	Due to (or as a consequ	Jence of):				1		
s the burial-transit	d								
Med	IF FEMALE:								
for use as	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal	death 3 Ectopic pregnant	ру		23d. Date of de Month	elivery Day Yea		
ed fo	1 Yes 2 No	4☐Pregnant at time of de 9☐Unknown	eath 5 Other (specify)						
y Physic	9 Unknown	23e Did tohar	co use contribute	to the cause of deat					
	Part II. Other significant conditions con	thought to death but not resc		☐ Yes 2 ☐ No 3 ☐ Probably 4 入 n					
should b	\		-						
page 2 should	.				24a. Was an autopsy	prior to	autopsy findings ava completion of caus		
. page 2 s					performe 1 ☐ Yes 2	d2 death? No 1 ☐ Ye	s 2 No		
Be Co	25. Was case referred to medical		delication and the state of the		th (Check only one)	V			
	1 ☐ Yes 🍇 ☐ No	lospital: 1 ☐ Inpatient 2 ☐			ome 5 Resident		ecify)		
		28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. Inj		28d. Describe how injury occurred				
tification:	1 Natural 5 Pending investigation		M 1[]Yes 2 □No					
ti ti	3 ☐ Suicide 6 ☐ Could not be determined	28f. Location (Stre City or Town,		Rural Route Number					
	building, etc. (Specify) City or Town, State)								
by fille		sician: To the best of my kno	wledge, death occurred at the tion and/or investigation, in my	time, date and place	, and due to the cau	e(s) and manner a	as stated. ue to the cause(s)		
completely filled in	(Check only 2 Medical Exami	and manner stated.							
E CO	29b. Signature and title of certifier	1-2-1	29c. Licei	nse number	290	. Date signed (Moi	nth, Day, Year)		
	Thomas I Treath 100 0001923 Feb 28,2								
-	30. Name and address of person who co	empleted cause of death (Iten	n 23a) (Type, Print)	N A A			1		
	TI France	and MD	1000008	090	20601				
State	31. Date filed (Month, Day, Year) MAR 0 4 2005	32. Registrate Signa		0)1)	- OUC V				

amend item#9, perFH, C841,3/9/05 The State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Ne 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2110 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number Examiner alisbury JICOMICO Jospice ake If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**X**M 2□F 215-70-296 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, It.» Medical Exactiver must be notified at 1 Yes 2 No Completed by Funeral Director Md. Worcester Bishopville 10e. Street and Number 10g. Citizen of What Country? 11414 St. Martins Neck Rd. U.S.A. 21813 Pages 1 and 2 should be filed within 72 hours after death vient of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or Items 23 arty or other traumatic event, it." Medical Event in all viry or other traumatic event, it." Medical Event in all virth and in the firement of the contract of the c 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Charles M. Smith Sr. Dorothy Kepper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda D. Glacken 11414 St, Martins Neck Ed. Bishopville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crem. 2-15-05 Salisbury, Md. 21. Signature of Funeral Service 22. Name and Address of Facility Ullrich Funeral Home Berlin, Md. 21811 23a. Part 1 Enter the divease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Physician ONR MON/N disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Box 68760. IF FEMALE esn 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) PO 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No has page 2 autopsy perh 1 🗌 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital* Other: Inpatient 2 ER/Outpatient 3 DOA 2 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? ate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: Natural 2 Accident 5 Pending investigation s after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T OLL 32. Registrar's Signature Date filed (Month, Day, Year, State Registrar 2005 FEB 1

DHMH 17 Rev 1/2001

		State of Maryland / Department of Health and Mental Hygiene 1- For State and Mental Hygiene Certificate of Death Rag. No. 0 0 5 0 7 3 5 8								158		
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day	Vaar	3. Time of	Death
	Physicia /Medic		George	Franklin S	eitz, J	r.		February		Year 005	4:20	A.M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County	of Death		
			College View Nursi	ng Center		Freder	ick		Free	deric	k	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day,	Year)	9. Birthpla	ace (State of	r Foreign
	Director		212-20-1165		84 Yrs.			Dec. 27		VA		
	and		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10	d. Inside Cit	tv Limits
	Manyl f sho	ō	Manual and Manual ar		Mars In a		1				1 🗌 Yes	•
	28a-	Funeral Director	Maryland Montgomer	У	Montg	omery Vil	rage	1	0g. Citizen of W	hat Count	rv?	
	with Sa or	0	8600 Bitterfield C	ourt		20886			USA		.,.	
	ns 2%	era		2. Was Decedent Ever	in U.S. 13.		ispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No-		- America	n Indian,	
(0	riter	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 XYes 2 ☐ No	1942-			Rican, etc.)	Black	c, White, e	tc.	
ဗ္ဗ	al', o	by	3X Widowed 4 □ Divorced	If Yes, Give	1945	1 ☐ Yes 2XX No	Specify:		Specify:		Vhite	
21215-0036	72 hours after deeth with the Maryland natural', or Items 23a or 28a-f show dical Evaruthed at	Completed by	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occupa	ation during most of working	20	16b. Kind of Bus			
7	within lene. than "u	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	<i>'</i> 9				
2	e filed within al Hygiene. other than ' vent, Ita Mu	S	12			Manager			Retail		ning	
Maryland	be filed within 72 hours after deeth with the Marylan ital Hygiene. Indicate than "natural", or Items 23a or 28a-f show event, if a Mudical Ever it with raist by notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			,		
<u>\S</u>	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 Is marked c any injury or other traumatic evence.	To			eitz, Sr			Florenc		Kauff		
<u>Ja</u>	2 sh and Is m	9	19a. Informant's Name/Relationship (Typ				and Number or Rura			175.7		
ď	l and fealth im 27 her t		Leslie Bruffey/Dau				1d Ct., M)886
0	A or of the		1 ☐ Burial 2 XCremation 3 ☐ Re	BINOVALITOTTI STATE		sition (Name of matory or other plac			20c. Location - (
븚	tmen tent:		'4 □Donation 5 □ Other (Specify)		letropoli	tan Crema	atory 2/15	6/2005 A	1exandr	ia, N	/irgin	ia
Baltimore,	Deparement of the property of		21. Signature of Funeral Service License	2/1000	/ // / / /		ss of Facility DeV					
	10260		OCO Parti Salvatha diagram as assault	< N COC	10		er Park Dr					
	2 On		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	death. Do not ent	er the mode of dyln	g, such as cardiac of	r respiratory arre	est,		Approximate Interval Betw Onset and D	veen
	Priysician	K A	Immediate Cause (Final disease or condition resulting in death)	Stroke							0,1000 0,100	Outil
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):							
		3	Sequentially list conditions, b.	Due to /or on a se								
	ed tis	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Tause Cliscana or Injury	Due to (or as a co	nsequence or):							
_	and I-tran	хап	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):							
8760,	cate be executed obysician and the burial-transit	A E		(0) 40 40								
687	phys phys the	g	d								-	
	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Medical	IF FEMALE:	Bc. If yes, outcome of pr	egnancy				23d Date	of deliver	,	
Вох	atter for u	clar	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			Mon			ear
o.		iys	1 U Yes 2 No 9 Unknown	9□ Unknown								
<u>α</u>	requires that the een signed by th nould be detache		Part II. Other significant conditions con-	tributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contri	bute to the	cause of de	eath?
ds,	ures rign	d by						1 ☐ Ye	s 2 No	3 🗌 Probai	bly 4☆U	nknown
00	w require been si should I	Completed						24a. Was ar	24h W	ere autops	sy findings a	vailable
Be	The law	m d						autops; perform	pr ned? de	ior to comp eath?	pletion of ca	use of
Vital Record		ပိ	25. Was case referred to medical				OO Diseased Death	1 Yes 2		☐Yes 2	No No	
	Physicien: this certificatal director, p	To B	examiner?	ospital:	2 ER/Outpatier	nt 3□ DOA Othe	26. Place of Death or: 4 🖾 Nursing Hon			· (Canaita)		
o			27. Manner of Death	28a. Date of Injury (Month, Day Yea		28c. Injury	at 2	8d. Describe ho				
Division	Attending F r death. ector: After by the funera	Certification;	1 XNatural 5 ☐ Pending investigation	(Month, Day Yea	ar) Injury	Work M 1□	<br Yes 2 □No					
N S		if Co	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury	At home, farm, str	eet, factory, office	2	8f. Location (Str	eet and Numbe	r or Rural i	Route Numb	per,
ā	spitel or A ours after nerel Dire	ert	4 - Homicide	building, etc. (S	овсту)			City or Town	, State)			
	Hospitel or 24 hours afte Funerel Dir stely filled in		29a. Certifier 1⊠ Certifying Phys	ician: To the best of my	knowledge, deati	occurred at the time	ne, date and place, a	nd due to the ca	use(s) and man	ner as stat	ted.	
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Examin	er: On the basis of exa and manner stated.	mination and/or in	vestigation, in my op	oinion, death occurre	d at the time, da	ite and place, ar	nd due to t	he cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License	number	29	d. Date signed	(Month, Da	ay, Year)	
,	1.1.1		1	>		D 60	0417	F	ebruary	15.	2005	
(411		30. Name and address of person who cor	npleted cause of death	(Item 23a) (Type,	Print)						
			Hemen P. Shah, M.D.	, 65C Thoma	as Johnso	on Drive,	Frederic	k, Maryl	and 217	02		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's S	Signature Signature	AP B						
	Registr	ar	FEB 1 7 2005	Alleva	15. 1900							

DHMH 17 Rev 1/2001

		State of Maryla				-	giene	.	
		1 - For State Registrar	-	rtificate of			Reg. No.2 0 ()	5 07350	
Physic	ian	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ath Day Yes	3. Time of Death	
/Medi	cal	Barbara Ann Strine		At Ch. Town		Februar	y 16, 200 4c. County of D		
Exami	ner	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			r Location of Death Frderick			t County	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		Birthplace (State or Foreign Country)	
Director		219-42-3944 1 1 M 2 N F 61	Yrs.	WOINTS Days	Hours Will.			aryland	
land ow		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	ocation				10d. Inside City Limits	
Mary 9-f sh	tor	MD Calvert County Ow	ings					1 ☐ Yes 2X No	
ith the	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?	
s 23e	eral	7815 Hampton Way	118 112 1	20736		naifu Van as Na	U.S.A.	merican Indian,	
fter de	Fune	11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1	0.3.	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, W	/hite, etc.	
rel', o	by	3 ₹ Widowed 4 □ Divorced If Yes, Give Year or Dates:		1□Yes 2∏ No	Specify:		Specify: W	hite	
13-UU30 172 hours after death with the Marylar "neturel", or Items 23e or 28e-f show citical Exerciper must be rudified at	letec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of Busine	ess/Industry	
within ene.	e Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired			Mant Dool	ring Company	
be filed within 72 hours after death with the Maryland hal Hygiene. Id Hygiene. Id other then "neturel", or Items 23e or 28e-f show event, the Marical Exerting must be rudified at		17. Father's Name (First, Middle, Last)	Packi	ing Super		e (First, Middle,	Meat Paci Maiden Sumame)	king Company	
VICII Suld be Menta Menta sriked	To B	Albert G. Bessette				Mae Pay			
2 sho		19a. Informant's Name/Relationship (Type, Print)					r, City or Town, State		
T and 1 and Health		Judy M. Taylor (Daughter) 20a. Method of Disposition 20b.	Place of Dispo	sition (Name of			yland 2073		
ages ent of ht: If it		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	natory or other place				Maryland	
Definition (e) Interpretable ALA 13-0030 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-1 show any injury or other treumatic event, the Medical Exertities injurial be indiffed at once.		21. Signature of Emplat Bervice Licensee	22	2. Name and Addres			1 Home Cal	lvert, P.A.	
0 88E58		Michael W. Lee 8125 Southern Maryland Blvd., Owings, MD 20736							
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deat							
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		curler.				57 months	
Examiner		Due to (or as a conse		(unler				11 years	
70 E	je l	Saluentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
verguines that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	calE	5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	querios or).						
oo/ tiflicate g phys as the		-							
ath cert	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fet		Ectopic pregnancy	,		23d. Date of Month	delivery Day Year	
the at	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	os 2 No 4 Pregnant at time of death 5 □ Other (specify)						
that the	y Ph		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.						
quires no sign uld be	ed by					1 🗆 Y	es 2□No 3□	□ No 3 □ Probably 4 ☑ Unknown	
law requires as been sign	ompleted	24a. Was an autopsy							
The law cate has I page 2 s	Com					perfor	med death	? 'es 2□ No	
VICION: The certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:		Oth	26. Place of Deat				
ding Physicien: h, After this certific funeral director,	To To	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injun	y at		ence 6 Other (S	pecify)	
tending death. tor: Afte the fune	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No							
or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At I building, etc. (Spec	home, farm, str lify)	eet, factory, office		28f. Location (S City or Tow	treet and Number or n. State)	Rural Route Number,	
pitel o		29a. Certifier 1 Certifying Physician: To the best of my kn	owledge death	occurred at the tin	ne date and place	and due to the	and manner	an eteted	
To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	edical	(Check only one) 2 Medicel Examiner: On the basis of examin one) and manner stated.	ation and/or inv	vestigation, in my o	pinion, death occur	red at the time, o	date and place, and o	due to the cause(s)	
To th withir To th comp	Me	29b. Signature and title of certifier		29c. Licens		2	29d. Date signed (Mo		
) cutter)			56024		17 Febru	ey 6005	
10		30. Name and address of person who completed cause of death (Ite Lenneth L. Askort 110 Hospilary)	m 23a) (Type,	Print)	10 Prince	Frederick	H) 20	678	
	ate	30. Name and address of person who completed cause of death (Ite Lenneth L. Askort IIO Hosy.) 31. Date filed (Month, Day, Year) FEB 1 8 2005	nature	1.0.					
Regist	rar	FEB 1 8 2005 Deser	as D.	Spense					

		ı	For State	State of Maryland /	Depa		ealth and l	Mental Hyg	_	
			Registrar 1. Decedent's Name (First, Middle, Las	t)		imouto of E	Journ	2. Date of Deat		3. Time of Death
	Physic /Medi	cal	Edward Harris Ste	einberg		4b. City, Town, or	Location of Deatl	February	Day Year 7 14, 2005 4c. County of De	10:00p ^M
	Exami	ier				Annapo			Anne Ar	
	Funeral		Sunrise Assisted 5. Social Security Number 6. Se	7. Age (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hrs.			inthplace (State or Foreign Country)
	Director		579-18-3156 Usual Residence of Decedent	₩ ^{2□} F 83	Yrs.	Months Days	Hours Min.	Feb. 1,	1922 Wa	shington, D.C
	larylan show	_	10a. State 10b. County	10c. City, Tov	wn or Loc	ation				10d. Inside City Limits
	8a-1 s	ecto	MD Anne Ar	rundel Anna	ipoli				0.00	1 □Yes 2 No
	With with the first	Funeral Director	10e. Street and Number 805 Coxswain Way	#302		10f. Zip Code	21401	1	og. Citizen of What C USA	ountry?
	ms 2:	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar		pecify Yes or No-	14. Race - Am	
980	be filed within 72 hours after death with the Maryland hal Hygiene. od other than "natural", or items 23a or 28a-1 show event, its Modical Evergizer must be routiled at	b	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: WW II		Yes, specify Cubai ☐ Yes 2 No	n, Mexican, Puert Specify:	o Rican, etc.)	Black, Wh	ite, etc. Thite
21215-0036	- 2	Completed	15. Decedent's Ed (Specify only highest gra			ent's Usual Occupa kind of work done d DO NOT use retired,		rking	16b. Kind of Busines	s/Industry
21	giene giene er the	E O	Community (0 12)	5+E	Execu	ative Dir	ector		Industria	l Laundries
nd	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, ILE MA	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M	faiden Sumame)	
yla	should ind Men	은	Samuel S. Steinbe					yn Dox		
Maryland	12 sh h and 7 Is rr rraurr		19a. Informant's Name/Relationship (7						City or Town, State,	
	ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic		Carol Swain/Daugh 20a. Method of Disposition	20b. Place	of Dispos	Marnel Di sition (Name of		Date	ark, MD 2	1146 r Town, State
пō	Pages nent of int: If it		1 ☐ Burial 2 【***Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State	•	atory`or other place matory		ruary 16,	Baltimo	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licen		22.	Name and Addres	s of Facility	005 .A. Seve	- 55	Funeral Home
111	20 E 2 9		Jeffen	a & felle	y 49	5 Gov. R	rtcure H	wy. Seve	erna Park,	MD 21146
	Physician		Shock, or leaf failure ist only of limmediate Cause (Final disease or condition	Approximate Interval Between Onset and Death a A 1 + 7 h = 1 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -						
	/Medical Examiner	ı	Due to (or as a consequence of):							9
	. sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of July) that initiated events	Due to (or as a consequence						
,092	te be executed ysician and ne burial-transit		that initiated events resulting in death) Last							
687	physicate by the b	dical		d. ==						
.O. Box (The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		Ectopic pregnancy Other (specify)			23d. Date of do	elivery Day Year
<u>a</u>	that the de led by the a detached i	Ph	Part II. Other significant conditions or	ontributing to death but not resulting	in the un	deriving cause give	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ords,	w requires that been signed should be dei	ted by						1 🗆 Ye	s 2 □ H0 3 □ F	robably 4 Unknown
Records,	sician: The law r certificate has be rector, page 2 sh	Completed						24a. Was ar autopsy perform 1 \(\sum \) Yes 2	ned? death?	autopsy findings available completion of cause of
Vital	ian: artifica ctor. I	Be	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one		
of V	Physician: this certificant ral director, i	To I	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	-		4 Nursing H		nce 6 Other (Sp	ecify)
ion c	utending P death. ctor: After t y the funera	ation;	27. Manner of Death 1	(Month, Day Year)	. Time of Injury	28c, Injury Work M 1 🗆 Y	at ? ∕es 2 □ No	28d. Describe ho	w injury occurred	
Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (Str City or Town	eet and Number or F , State)	Rural Route Number,
	e Hospli 24 hour e Funera letely fille	Medical (ysician: To the best of my knowledg niner: On the basis of examination a and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and the of certifier			29c. License		29	d. Date signed (Mor	th, Day, Year)
			18 Wen	- MD			16964		2/15/	os
			30. Name and address of person who	nacours 1509	(Type, F	Print) Ychi	e Hu	Jy Aru	ald MD	21012
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Egistrar's Signature		and !		/		

DHMH 17 Rev 1/2001

			1- For State of Maryland / Depart State of Maryland / Depart Cert	rtment of Health and Me	ntal Hygie	4000	07361
	Physici	an.	Decedent's Name (First, Middle, Last)	2.	. Date of Death		3. Time of Death
	/Medic	al	DORLA AGNES SOWERS		EBRUARY	28 2005	7:15 A.M
	Examin	er	4a. Facility Name (If not institution, give street and number) 10926 SUGAR ROW ROAD, NW	4b. City, Town, or Location of Death FROSTBURG		4c. County of Deat ALLEGANY	
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth (Month, Day, Y	9. Birt	hplace (State or Foreign
	Director		215 26 9279 75 Yrs.	Months Days Hours Min.	SEPT 6 1	929 PEN	NSYLVANIA
	iand ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
	Mary a-1 sh	tor	MARYLAND ALLEGANY FROSTBUE	RG			1 ☐ Yes 🍇 ☐ No
	ith the or 28:	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
	s 23a		10926 SUGAR ROW ROAD, NW	21532		U.S.	
	iter de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	as Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, White	
5-0036	ours at	by	3 ₹ Widowed 4 □ Divorced If Yes, Give Year or Dates:	☐ Yes 2X No Specify:		Specify:	WHITE
2	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show he Medical Examinar must be notified at	Completed	(Specify only highest grade completed) (Give ki	ent's Usual Occupation ind of work done during most of working	16	b. Kind of Business/	Industry
2121	within ene. than	omp	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired) OMEMAKER		OWN HOME	,
5	filed Hygid other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Ma		4
Jar	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. s marked other than "natural", or Items 23a or 28a-1 show umatic event, the Medical Examiner must be notified at	To B	EDGAR BRIDGES	GRACE REA	M		
Maryland	2 a a a			Address (Street and Number or Rural R $5~\mathrm{SUGAR}$ ROW ROAD, N			
	is 1 and of Health item 27 other tr		20a. Mathod of Disposition 20b. Place of Disposit	ition (Name of		. Location - City or	
ltimore,	Page ient o nt: If		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	VALE, MAR	YLAND		
$\boldsymbol{\omega}$	permit. Departm Importa any inju			Name and Address of Facility		O W. MAIN	
m	70 E 2 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter	VERS FUNERAL HOME,			MD 21532
ls.	= -1		shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or re	espiratory arrest		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	9 Junes			months
	Examiner						
T	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
V	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last Due to (or as a consequence of):				
760	ate be e	dical E	d				
89	artifica ing ph		IF FEMALE:	100			
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of deli Month	very Day Year
o.	the d by the ached	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)			
o. O.	w requires that been signed b should be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the und		23e. Did tobac	co use contribute to	the cause of death?
ord	raquire aen si	ted	Chromic Obstructive Volon	onmy listest	1 🗆 Yes	2 □ No 3 □	pbably 4 □Unknown
Vital Records,	: The law cate has by page 2 sh	Completed			24a. Was an autopsy	_ prior to d	topsy findings available ompletion of cause of
<u></u>		e Col	25. Was case referred to medical		performed 1 ☐ Yes 2		2 No
	ysician: s certific director,	0 8	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (C		e 6 FlOther (Spec	ify)
<u>_</u>	ng Phys fter this neral dii	n: T	27. Manner of Death → Natural → Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		. Describe how		,,
<u>S</u>	tendii death. tor: A the fu	catio	2 Accident investigation	M 1 Tyes 2 No			
Division of	N or Attending P after death. I Director: After I d in by the funera	Certification:	4 Homicide determined determined determined building, etc. (Specify)	et, factory, office 28f.	City or Town, S	t and Number or Ru tate)	ral Route Number, .
	pits oral		29a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or inve	occurred at the time, date and place, and	due to the caus	e(s) and manner as	stated.
	To the Hos within 24 ho To the Func completely f	Medicai	one) 7 and manner stated.	29c. License number			•
	T w c		29b. Signature and title of certifier		290.	Date signed (Month	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	D21244		21/12	003
	10		JESUS TAN, M.D., FROSTBURG PLAZA, FR				
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
			MAR 0 4 2005 Blace & So	SEE F			

		1 - For Unpend Item Registrar		ind G84.	rtificate of	lealth and Eas Death			05	07362
Physicia /Medic Examine	al	Decedent's Name (First, Middle, Lass Brenda Facility Name (If not institution, give 838 Virginia Ave:	Kay			r Location of Dea		ry 20,	nty of Deat	h
Funeral Director		5. Social Security Number 6. S		rs. last birthday) Yrs.	Hagers If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month Da	Was th ay, Year) 2, 1963	9. Birtl	On County hplace (State or Foreign unity) yland
death with the Maryland ms 23a or 28a-f show rmust be rottled at	ector	10a. State 10b. County MD Washingt		City, Town or Lo	own			100 000		10d. Inside City Limits 1 X Yes 2 □ No
72 hours after death with the Marylan natural', or Itams 23a or 28a-f show lical Examiner must be notified at	Funeral Director	838 Virginia Ave	Was Decedent Ever in Armed Forces?	U.S. 13.	10f. Zip Code 2174 Was Decedent of Hilf Yes, specify Cuba		Specify Yes or No		S.A.	ncan Indian,
72 hours after natural', or Ita alcel Examine	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:	to Hican, etc.)	Spe	Black, White city: Whi	te
d within 72 jiene. ir then "nat tre Madie:	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired ing Coord	during most of wo d)		16b. Kind of Lowes		Improvemen
al H d out	To Be C	17. Father's Name (First, Middle, Last) Elvin P. Slayman				Sarah	me (First, Middle E. Shub	ert		
5 5 5 E		19a. Informant's Name/Relationship (TElvin P. Slayman/ 20a. Method of Disposition	Father	1404	ng Address (Street Marshall sition (Name of	St. Hag			1740	
permit. Pages 1 ar Department of Hea Important: If item any injury or othe		1 ∰ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif) 21. Signature of Funeral Service Licen) Re	est Have	osition (Name of matory or other place or Cemete 2. Name and Addre	ry 2/24 ss of Facility R	/2005 est Have	Hagers n Fune	town, ral C	MD Chapel
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or composhock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Necrotizing Due to (or as a cons	Bronchi equence of):	tis and l	ng, such as cardia	c or respiratory a		WII, M	Approximate Interval Between Onset and Death
te be ysicia ne bur	Ical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	едивлов об.	.nfection					
The law requires that the death certifica tte has been signed by the attending ph nage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ◯ Unknown	23c. If yes, outcome of preduced the second of the second	etal death 3	Ectopic pregnancy Other (specify)	,			Date of deli	very Day Year
w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions o	ontributing to death but not	esulting in the u	nderlying cause giv	en in Part I.		obacco use co Yes 2 🗆 No		the cause of death?
								an 24l psy prmed? 2 \(\text{No} \)	b. Were autorior to condeath?	topsy findings available completion of cause of
h bis								dence 6 🕱 C		ity) At scene
ol or Attending Physician: after death. I Director: After this certification by the funeral director.	edical Certification;	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		t home, farm, sti	Wor M 1□	yat k? Yes 2 □ No	28d. Describe I	Street and Nui		ral Route Number,
ne Hospitel or 24 hours afte na Funeral Dire bletely filled in b	ical Cer	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my kaliner: On the basis of exam	knowledge, deat	n occurred at the tir	ne, date and place	e, and due to the	cause(s) and	manner as e, and due	stated. to the cause(s)
To the I within 2 To the I complet	Med	29b. Signature and title of certifier	and manner stated.	/	29c. License number 29d					n, Day, Year)
		30. Name and address of person who	completed cause of death (I	A te 23a) (Type,		Penn Stre	eet Ral			l, 2005 yland 21201
Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature			1041	-INOLE	TELL	y 1 an 10 2 1 2 0 1

DHMH 17 Rev 1/2001

ORIGINAL

		Registrar				ind / Depa	rtificat	e of L	Death			Reg. No.	05	07363
Physici	ian	Decedent's Name (First,		ist)							2. Date of De Month	eath Day	Year	3. Time of Death
/Medic		Mavis Flora Swe									FEBRUA	RY 23		8:30 a
Examir	ner	4a. Facility Name (If not ins	_	ve street and num	iber)				Location	of Death			ounty of Dea	
		St. Mary's Hospi 5. Social Security Number		Sex	7 Age (In vis	s. last birthday)	If Under	eonard	Itown If Under	24 Hrs.	9 Date of Pi	1 .	. Mary'	
Funeral Director		578-24-7948		1 □ M 2 X □ F	83	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da May 24,	1921	C	rthplace (State or Fore country) yland
3 ::		Usual Residence of Deceder 10a. State 10b. C			10c C	City, Town or Lo	ocation							10d. Inside City Lim
ods	ō				100.0									1 ☐ Yes 2 🛣
natural', or items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	Maryland S	St. Mai	ry's		Ho11ywo	10f. Zip	Code				10g Citizo	n of What Co]
Pa or	Ö	24632 Hollywood	d Road					0636				US		ourity :
TIS 2	era	11. Marital Status	u modu	12. Was Dece	dent Ever in	U.S. 13.			ispanic Ori	igin? (Spe	ecify Yes or No			erican Indian.
r Iter	ᇤ	1 Never Married 2	Married	Armed For 1 ☐ Yes	ces? 2 ▼ No						ecify Yes or No Rican, etc.)		Black, Whit	
al, o	by	3 XWidowed 4 ☐ Div	vorced	If Yes, Give Year or Da	9		1 🗆 Yes :	2X No	Specify:			S	pecify: Wh	ite
lical	Completed	15. De	cedent's E	ducation ade completed)		16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of worki	ina	16b. Kind	of Business	s/Industry
e. Med	ple	Elementary/Secondary (0		College (1-	-4or 5+)	life.	DO NOT us	se retired))	d OF WORK	ng			
Hyguen other th ant, the	Con	7				Bus D	river					Trans	portati	.on
d oth	Be	17. Father's Name (First, M	fiddle, Last	1)					18. Mothe	er's Name	(First, Middle	, Maiden Su	imame)	
and Mental Hygiene. Is marked other than sumatic event, the Ms	²	Briscoe Philli	p Thom	pson					D	aisy (Catherine	Jones		
la m		19a. Informant's Name/Rel	lationship ((Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	d Route Numb	er, City or T	own, State,	Zip Code)
of Health Item 27 I		Daniel Bicknell		ney, Jr./S		_			ck Roa	-	llywood,	11		
of H If Itel		20a. Method of Disposition 1 XBurial 2 ☐ Crem		Removal from S	State	Place of Dispo cemetery, crer	natory or o	ther plac		_	ate	20c. Loca	tion - City or	Town, State
ant: If its ury or o		° 4 □Donation 5 □ Ot			Ho Na	Hywood (Church emetery	of tl	ile	2005	ry 24,		ood, Ma	
Department of Health and Mental Hygiene. Important: if Items 23e or 28e-f show Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Se	arvice Lice	nsee Ark	lose	22	. Name an P. C	d Addres Boz	s of Facilit x 270 ,	^{ly} Mati Leona	tingley-(Gardine Maryla	r Funer	ral Home, P.A
nysician Medical		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	as or com s. List only		used the dea		A 15-35		g, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death
xaminer.			- 6	Due to (d	or as a conse	equence of):	,	11	tic.	Par	dure	-		Zdays
sician and a burial-transit	sal Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	• {	b. A Constitution of the c	or as a conse or as a conse or as a conse	equence of): Stuce equence of): Sdy Kin	,	11	noly	tic	Anes	mic		z days years
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DHMH 17 Rev 1/2001

MAVIS F SWEENEY

			1 - For State Registrar	tate of Marylan			of Health a of Death		giene Reg. No. 005	07364
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) Rose Cecelia Stev					2. Date of De Month Februa:	Day Year ry 22, 2005	
	Examir	ner	4a. Facility Name (If not institution, give stree St. Mary's Nursing 5. Social Security Number 6. Sex		last birthday)	Leon		1 24 Hrs. 8. Date of Bin	4c. County of Dea St. Mar th 9. Bir	y S
	Director		217-30-4747		89 Yrs.		ays Hours	Min. (Month, Da Aug. 1	v. Year) Co	cyland
	the Maryla 28a-f shov	rector	Maryland St. Mary		y, Town or Lo		hanicsv:	ille	10g. Citizen of What Co	10d. Inside City Limits 1 Tyes 2 No
036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "naturel", or Items 23e or 28e-1 show traumetic event, the Medical Examinat must be notified at	by Funeral Director	1 Never Married 2 Married	Was Decedent Ever in U. Armed Forces? □ Yes 2 ■ No f Yes, Give fear or Dates:			20659 of Hispanic Ori Cuban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	United Sta	ntes encan Indian, e, etc.
21215-0036	within 72 ho lene. Ithan "natur he Medical I	Completed			(Give	dent's Usual O kind of work d DO NOT use re COO	one during mosi etired)	t of working	16b. Kind of Business.	·
Maryland 2	2 should be filed withing and Mental Hygiene. Is marked other than aumetic event, the Mental than a should be seen and the Mental than Me	To Be Co	8 17. Father's Name (First, Middle, Last) Peter Holt					r's Name <i>(First, Middl</i> e, Mary Regi	Maiden Sumame)	vice
	is 1 and 2 sho of Health and I item 27 Is ma other traume		19a. Informant's Name/Relationship (Type, Information of Disposition 19a. Method of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Information of Disposition 19a. Informa	reat Niece	26145	Barnes	Court,		ville, MD 2	0659
Baltimore,	permit. Pages Department of It Important: If ite eny injury or of		1 Burial 2 Cremation 3 Remote 4 Donation 5 Other (Specify) 21. Sometime Funeral Services Licensee Edward N. Brinsfield	St	. John	. Name and A	etery 2	2-26-2005 Brinsfield	Hollywood, d Funeral H ardtown, MD	Maryland
8760,	Physician /Medical Examiner up prize	cal Examiner	23a. Part1. Enter the disease, or complicatic shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	on st uence of): on a uence of): Linta	nocle	alnuty	cardiac or respiratory and the second and the secon		Approximate Interval Between Onset and Death mmh
.O. Box 68	The law requires that the death certificate be executed te has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	f yes, outcome of pregnal □Live birth 2 □ Fetal □Pregnant at time of de □ Unknown	death 3	Ectopic pregn Other (specif			23d. Date of del Month	ivery Day Year
Δ.	w requires that t been signed by should be detai	by	Part II. Other significant conditions contributions of the pulmentary	nting to death but not resu	ulting in the ur	nderlying cause	given in Part I.		obacco use contribute to ∕es 2 ☑No 3 ☐ Pr	
Il Reco		Completed	Thombosis, Ostcoar	Mur. tro Boci	M				an 24b. Were au prior to death? 22/20 1 2 Yes	topsy findings available completion of cause of
Division of Vital Records,	ding Physiclan: Th h. After this certificate funeral director, pag	lon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Natural 5 Pending	26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) e of 28c. Injury at Work? 28d. Describe how injury occurred						
Divisio	tent feath for: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	Be. Place of Injury - At ho building, etc. (Specify			1 ☐ Yes 2 ☐ I		Street and Number or Ru vn, State)	iral Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the	ne time, date and my opinion, deat	d place, and due to the o	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	To the H within 24 To the F complete	×	29b. Signature and title of certifier	$\frac{7}{2}$ mp		D	J - 1	38	29d. Date signed (Mont)	505
	29.0		30. Name and address of person who comple	24435 N	nervi	Print)	DEAN F	2D, HOLL	IWOOD, M	D 20636
	Sta Registi		31. Date filed (Month Cay Year) 5 2005	32. Agistrar's Signat		and o				

			For State Registrar		State of	Marylar		artment of	Health and N		giene	05	07365	
	Dhusis		1. Decedent's Name ((First, Middle,	Last)					2. Date of Dea	ath	Vaar	3. Time of Death	
	Physic /Medi		Agn		Irene		Tramme	ell		Februa	ry 15,	2005	3:00 p M	
	Examir	ner	4a. Facility Name (If n			· ·			, or Location of Death		4c. County			
	-		5. Social Security Num		al Hospita	a⊥ 7. Age (In yrs.	(ast hirthday)		Frederick or If Under 24 Hrs.	8. Date of Birt		vert		
	Funeral Director		579-24-04		1□M 2₩F	89	Yrs.	Months Day	s Hours Min.	(Month, Da)	v, Year)		ace (State or Foreign try)	
			Usual Residence of D	ecedent						1 OCT 19	, 1915	COM	ecticut	
	arylar show	_	10a. State 1	10b. County		10c. Cit	ty, Town or Lo	cation				10	Od. Inside City Limits	
	ле Мё	ecto	MD		lvert			St. Lec					1 ☐ Yes 2 ☐ No	
	hours after death with the Maryland tural', or Items 23a or 28a-f show at Exercities invest be inclined at	Funeral Director	10e. Street and Numb					10f. Zip Code			10g. Citizen of V	What Count	try?	
	eath	era	5752 Oak	Crest	Drive	tent Ever in 11	S 12 1		1685		US			
(0	fter d	Fu	1 Never Married	d 2⊟ Marriec	Armed Ford	ces?	.5.	Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	Blac	e - America k, White, e		
036	ours a	by	3 ₩ Widowed 4		d 1 □ Yes 2 If Yes, Give Year or Da	tes:		I□Yes 2∏ N	o Specify:		Specify		±	
2-0	72 hc 'natur	Completed	1: (Specify	5. Decedent's	Education grade completed)		16a. Deced	lent's Usual Occi	upation	ina	16b. Kind of Bu	whi usiness/Ind		
2	within ene. than "	npl(Elementary/Second		College (1-	4or 5+)	life. L	OO NOT use retir	e during most of work red)	ing .				
2	filed w Hygien other the		12 17. Father's Name (Fit	ient Middle Le	act)		acco	unts red	ceivable c		state		rsity	
anc	ontal H	Be c	_	TSI, MIGGIO, LA	(51)				18. Mother's Name		Maiden Sumam	,		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours If Health and Mental Hygiene, item 27 is marked other than "natural; other traumatic event, I'ra Medical Exe	70	James 19a. Informant's Nam	ne/Relationshic	(Type, Print)	Murr		a Address /Stree	Lucinda et and Number or Rura		r City or Town		ndass	
¥a			Paul J. M	•									_	
ē,	s 1 and if Health item 27 other tr		20a. Method of Dispos		ugii, or.,	20b. P	lace of Dispos	sition (Name of	er Dr., Sp	ringite. Date	20c. Location -	2215 City or Tov		
ê E	Page: ent of nt: If i		1 Burial 2 0		☐Removal from Si	iale !		natory or other pl	etery 02–18	3-2005	Damascu			
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Fine		• *	100		Name and Add		2005	Daniasco	D, ME	,	
ä	Departing Department of the partment	1/10	dom	K. (12	2	ī	Rausch F	uneral Hon	ne D 1	Owino	re MT	20736		
			23a. Part1. Enter the shock, or heart f	disease, or co	omplications that car	used the death	h. Do not ente	or the mode of dy	ring, such as cardiac o	or respiratory arr	est,		Approximate Interval Between	
	Physician		Immediate Cause (Fir disease or condition		(1.	a 11	10	e 1	1 /2/10	00/	Or a		Onset and Death	
	/Medical		resulting in death)	6	Due to (o	r as a consequ	uence of):		runco	2 Ch	unat	4		
	Examiner		Sequentially list condi	itions.	b. Cer	de	9711	Soul	as dro	Lende.				
	be sit	Examiner	Sequentially list condi if any, leading to imme cause. Enter Underly Cause (Disease or inju-	ediate ing	Due to (or	r as a consequ	uence of):	,	Λ	. /-				
_	and A-tran	хап	that initiated events resulting in death) Las		c. Thursday	UT (en V	Lon	, ales	She				
8760,	cate be executed obysician and the burial-transit			- 0	7/		(4)	00	/					
687	ficate physics ts the	edical			d	mu	(0	PD.						
Division of Vital Records, P.O. Box 6	death certifica attending ph d for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, outco	ome of <u>pr</u> egna					23d Date	e of deliver	v	
S.	death	Icla	in the past 12 mo 1 ☐ Yes 2 🕱 N	onths?	4 ☐ Pregnar	th 2 Fetal nt at time of de		Ectopic pregnand Other (specify) _	су		Mor		Day Year	
10.	t the	hys	9 Unknown		9□ Unknow									
S	og og	by F	Part II. Other significa	ant conditions	contributing to dea	th but not resu	ulting in the un	derlying cause g	iven in Part I.	23e. Did tol	bacco use contr	ibute to the	cause of death?	
ord	w require been si should I								-	1 🗆 Ye	es 2 No	3 ☐ Proba	bly 4 □Unknown	
, go	S S S	Completed								24a. Was a		Vere autops	sy findings available pletion of cause of	
THE H	Th ate pag	Con								perform	ned? d	eath?	!□ No	
C'ù	ysician: The lis certificate ha		25. Was case referred examiner?	to medical					26. Place of Death	(Check only on	e)			
30	Physician: this certific ral director,	2	1 Yes 2 No)			ER/Outpatient	JU DOX	ther: 4 - Nursing Hor					
) u	After After fune	lon		5 Pending	28a. Date of (Month,	Day Year)	28b. Time of Injury	28c. Inju		28d. Describe ho	w injury occurre	ad		
isi	Attending in death. ector: After by the fune	licat	2 Accident 3 Suicide	investigati	be 200 Place	Injuny At ho	1500	et, factory, office		28f. Location (St	reat and Number	or Ourol	On the Million	
Div	I or A after Direct	Certification:	4 Homicide	determine	building	, etc. (Specify	()	at, raciory, office		City or Town	, State)	ir Or Hurari	HODIO INDINDOI,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier	Certifying F	Physician: To the b	est of my know	wledge, death	occurred at the t	ime, date and place, a	and due to the ca	ause(s) and mar	ner as stat	led.	
	ne Ho n 24 h ne Fu oletely	edical	(Check only 2 [*] [one)	☐ Medical Exa	aminer: On the bas and manne	is of examinat	tion and/or inv	estigation, in my	opinion, death occurre	ed at the time, de	ate and place, a	nd due to t	he cause(s)	
	To the within 2 To the complet	Ž	29b. Signature and title	e of certifier	1 1	/		29c, Licen	se number	2	9d. Date signed	(Month, Da	ay, Year)	
			Glu	v4/1		La		DI	2705		2/16	100	,	
-	. ^		30. Name and address	s of person who	o completed cause	of death (Item	23а) (Туре, Р				x/IV/	<u> </u>		
ال	2		EMAL	2 /	1. 11	1519	NN,	1	40.					
	Sta Registr		31. Date filed (Month,	Day, Year)	2005 ▶	istra s Signat	ture .	1						
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			for State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of I		-	giene 005	07366
	Dhusisi		1. Decedent's Name (First, Middle	, Last)				2. Date of Dea Month		3. Time of Death
	Physici /Media		HELEN MARY TUS					FEBRUA	•	NA.
	Examir	er	4a. Facility Name (If not institution	, give street and num	ber)	4b. City, Town,	or Location of Dea	th	4c. County of Dea	ath
			CASEY HOUSE 5. Social Security Number	6. Sex 7	7. Age (In yrs. last birthday,		VILLE If Under 24 Hrs	l O Data of Displ	MONTGOM	
	Funeral Director			1 M 2 1 F	Yrs	Months Days		. (Month, Day	, Year) C	inthplace (State or Foreign Country)
	р.		386-18-8862 Usual Residence of Decedent		81			JAN_2	27, 1924	MICHIGAN
	anylar show	7	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	the M	Director	MARYLAND MONT 10e. Street and Number	GOMERY	SILVER	SPRING				1 ☐ Yes 2 XNo
	with a or		-1-31			10f. Zip Code		1	log. Citizen of What C	ountry?
	death	Funerai	3373 S. LEISUR	12. Was Deced		Was Decedent of I		Specify Yes or No- to Rican, etc.)	USA 14. Race - Am	erican Indian.
9	or ita	F	1 ☐ Never Married 2 ☐ Marri	ied 1 Yes 2	2 □ No			to Rican, etc.)	Black, Wh	
003	hours after death with the Maryland tural', or Itams 23s or 28s-f show al Exer: it we trues be notified at	d by	3 ₩idowed 4 Divorced	If Yes, Give Year or Dat	Res: WWII	1 ☐ Yes 2 ☑ No	Specify:		Specify:	WHITE
21215-0036	72 Ina	Completed	15. Decedent (Specify only highes	's Education it grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Business	s/Industry
12	within lene. then "	omp	Elementary/Secondary (0-12)	College (1-	4or 5+)		,		MIDGING	
5	e filed within al Hygiene. other then '	Be C	17. Father's Name (First, Middle,	Last)	UFF.	ICE ASSIS		me (First, Middle, I	NURSING Maiden Surname)	
lar	Aental rked c	To B	JOHN STEFANOWI	CZ			ALBIN	A KOLOWIC	37.	
Maryland	s 1 and 2 should be f Health and Mental itam 27 is marked other traumatic ev	Ċ	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Maili	ng Address (Street			; City or Town, State,	Zip Code)
	7573		CASS_TUCKER/SO	N			TER BAY		rA, VA 241:	21
Baltimore,	permit. Pages 1 and Department of Healt Importent: if item 2 any injury octother once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from S	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other pla	ice)	Date	20c. Location - City or	Town, State
ţ	t. Pa		'4 □Donation 5 □Other (S)		FORT LING	COLN CREM	ATORY FE	В 18, 200)5 BRENTW	OOD, MD
Ba	Dermi Depa Impo any i		21. Signature of Funeral Service I	LICENSEE					DI FUNERA	
			23a. Part1. Enter the disease, or	complications that car	used the death. Do not en	L800 NEW ter the mode of dvi	HAMPSHIR	E AVE, SI	LVER SPRI	NG, MD 20904
	Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	one cause on ear				o a respiratory arm		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	HEPATIC FAII ras a consequence of):	LURE				
r	Examiner		Conventingly link and distance	h	END STAGE CI	RRHOSTS				
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	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	cate be executed physician and the burial-transit	ai E		Due to (or	r as a consequence of):					
687	icate phys s the	edicai		d						
Вох	The law requires that the death certific lie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnancy				23d. Date of de	Nivery
	ne death the atte	icia	in the past 12 months? 1 ☐ Yes 2 🎇 No	4☐Pregnar	nt at time of death 5	Ectopic pregnancy Other (specify)	у		Month	Day Year
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	igned be de	þ	Part II. Dther significant conditio	ns contributing to dea	th but not resulting in the u	nderlying cause gru	en in Part I.		acco use contribute to	
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ō	유 부 등	-	27. Manner of Death	28a. Date of	Datient 2 ☐ ER/Outpatien Injury 28b. Time of	28c. Injur	y at		ince 6 MOther (Spe w injury occurred	ecity) Hospice
ion	tanding lasth. tor: After the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investig	9	Day Year) Injury	Woi	rk? Yes 2 □ No			
Division of		Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of	f Injury - At home, farm, str g, etc. (Specify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or Ri	ural Route Number,
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	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Medical	Check only 2 Medical 5	examiner: On the bas	est of my knowledge, death is of examination and/or in-	occurred at the tirvestigation, in my o	me, date and place ppinion, death occu	, and due to the ca	use(s) and manner as	s stated.
	o the ithin 2 o the omple	Mec	one) 29b. Signature and the of contribute	and manne	r stated.	29c. Licens			9d. Date signed (Mont	
			XTOM	1					2/15/0	
	10	-	30. Name and address of person v	who completed cause	of death (Item 23a) (Type.		11418	•	C/17/U	2
			CHARLES HARRIS		UNCASTER MIL	,	CKVILLE	MD 20855		
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			1 - For State Registrar	State of Maryland		artment of H		ind M		giene	005	0736	7		
			1. Decedent's Name (First, Middle, La	st)				T	2. Date of Dea	ath		3. Time of Death			
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	death ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. \			in? (Spec	ify Yes or No-		China Race - Amer	can Indian			
9	or Ital	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of His f Yes, specify Cubar		Puerto R	ican, etc.)	1.4.	Black, White				
03	ral', c	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Yes ZII No	Specify:	20		Sp	pecify: Or	iental			
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-1 ahow the Madical Examiner must be notifized at	Completed	15. Decedent's Education (Specify only highest gra	ducation 1	6a. Deced	lent's Usual Occupa kind of work done d	ition			16b. Kind	of Business/Ir				
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Maryland	12 st h and 7 Is n traun		19a. Informant's Name/Relationship (g Address (Street a									
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, Ire Modical Examiner must be notified at		Anna Mei (Data 20a. Method of Disposition	ughter)	ODispla	503 Haw	ks Ne	∋st Da	La, G	ermar	ntown,	Md			
Baltimore,	Pages ment of P ury or of		1 ☐ Burial 2 🖾 Cremation 3 🗆		11 1	sition (Name of natory or other place	,				tion - City or T				
Ħ	permit. Pages Department of Important: If i any injury or once.		' 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Ineral Service Licer	7 7 7 - 9 63	rø C	rematory Name and Address	7 2/	31/	05 2	Alexa	indria	, Va			
Ba	permit. Departr Importa any inju		Jemai	The View of	1/2	A N 1375	s of Facility	Snov	wden l	uner	cal Ho	me			
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of	S S	은	163 2 210	Hospital: 1 ☐ Inpatient 2 ☐ ER/0		3 DOA Other	4 Nursi				Other (Specify	<i>'</i>)			
	ing After une	lon	27. Manner of Death 1XX atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Time of Injury	28c. Injury a Work?			d. Describe ho	w injury oc	curred				
Si	tan leat lor: the	cat	2 Accident investigation 3 Suicide 6 Could not be				es 2⊡No	-							
-	- 0 = -	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		281	Location (St. City or Town	reet and Nu n. State)	umber or Rura	l Route Number,			
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exam	rsician: To the best of my knowled iner: On the basis of examination a and manner stated.	and/or inve	estigation, in my opir	nion, death	occurred	at the time, da	ause(s) and ate and plac	I manner as st ce, and due to	ated. the cause(s)			
	To th withir To th	Me	29b. Signature and title of certifier			29c. License r	number		25	9d. Date sig	gned (Month, I	Day, Year)			
)			> Mulson	lecias - PHY510	CIAn	D-	438	69			6/05				
	1		30. Name and address of person who c							, - \	,	20878			
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	Stat		31. Date filed (Month, Day, Year)	3 Registrar's Signature	dos	les									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** *Ihompsor* 2 A M 3,200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner undel Hnhapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay 9. Birthptace (State or Foreign Security Numbe 6. Sex Age (In yrs. last birthday **Funeral** Days Min 1 □ M 20 F Director lay Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 show Examinar must be notified at 1 Yes 2 No Directo Mary and F 10e. Street and Number 10f. Zip Code 10g. Citizen of What-Country? "naturel", or items 23£ or 140 ~es Funeral Was Decedent Ever Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 21 No Black 1 Yes Specify à Specify: 3 Widowed 4 □ Divorced Be Completed or other treumetic event, It's Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Ker permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Importent: If item 27 is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 rle Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or City or Town, State, Zip Code) on 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) injury 21. Signature of Jungral Service License 22. once. anyi complimations that call Do not enter the mode of dying, suc P 11. Int Liv disease, or complications t shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transi the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE use 23c. tf yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy for Day Year 5 Other (specify) should be detached 9□ Unknown 9 Unknown signed by (23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. λq 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2□ No 2 🗆 No 1 Tes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📑 No P 1 Tyes 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel I 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicet Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

Registrar

State

29b. Signature

d cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** ROBERT ERVIN TAFT FEBRUARY 22 2005 9:25 A /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHARLOTTE HALL VETERANS HOME CHARLOTTE HALL ST. MARY'S If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 579-40-1746 Director 76 AUG. 19. 1928 TEXAS Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Count item 27 is marked other then "neturel", or items 23s or 28e-f show other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director MD CALVERT PRINCE FREDERICK 10e. Street and Number 10g. Citizen of What Country? 420 WEST DARES BEACH ROAD APT. 102 20678 S. Α. death 12. Was Decedent Ever in U.S. Amed Forces? 153 es 2 □ No 17 es, Give Year or Dates: 150-152 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "neturel", or ite 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8 CARPENTER CARPENTRY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) CLARENCE ARTHUR TAFT EVA FAY STAIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an G. FAY MILLER / NIECE 20A RIDGE ROAD GREENBELT, MARYLAND 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Importent: If iter
any injury or oth 1 ☐ Burial 2XDCremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) BRINSFIELD-ECHOLS CR. 2/24/2005 CHARLOTTE HALL, MD 22. Name and Address of Facility BRINSFIELD-ECHOLS FUNL. HME., P.A. 21. Signature of Funeral Service Licenses M00641 30195 THREE NOTCH RD. CHARLOTTE HALL, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physicien certificate be Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) à been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: of or Attending Patter death. 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours at To the Funeral Completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 2-24-05 281 22 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person William D. Boyd Point Lookout Road, Leonardtown, MD 20650 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 305 A CONTRACT Registrar

		State of Maryland / Depa			ne _{2 n n 5}	07270
		1 - State Registrar Cen	tificate of Death	Reg. I		0/3/0
Physic	ion	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
/Med		Ethyl Mae VanGilder	4b. City, Town, or Location of Death	02/14/200	4c. County of Death	3:45 AM
Exami	ner	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	Annapolis	A	anne Arundel	l
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		e (State or Foreign
Director		232-58-2640 1□M 2♥F 67 Yrs.	Monais Days Tiodio IIIII	09/08/193	7 West	Virginia
pu s		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	eation		10d	. Inside City Limits
Maryle f sho	ō	Maryland Prince Georges Bowie				1 XYes 2 □ No
r 28a-	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country	/?
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iryla should ad Mei mark matic	7		g Address (Street and Number or Run		ity or Town, State, Zip C	code)
Ma nd 2 st alth ar 27 ts r trau			Win foot Drive Mi			
or 1 a		1 Durio 2 VCremation 3 Demoval from State	natory or other place)		. Location - City or Tow	
Page ment gant: If		'4 □Donation 5 □ Other (Specify) RuitCC CF6	ematory 02/18 Name and Address of Facility Rob		ldorf, Mary	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or items 23s or 28s-f show any injury or other traumatic event, if a Medical Examinat mast be rightlind at		16	5000 Annapolis Roa	nd Bowie,	MD 20715	I Home
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of Vital F Physician: Th r this certificate ral director, pag	B	25. Was case referred to medical examiner?	Other	th (Check only one)	ce 6 ☐ Other (Specify)	
Of Physical direction	2	1 Yes 2 Produpation 200 Pate of Pine 2	f 28c. Injury at	28d. Describe how		
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Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
Hospital 24 hours Funeral etely filled	Medical		h occurred at the time, date and place vestigation, in my opinion, death occu	rred at the time, date	and place, and due to	uie cause(s)
To the Hi within 24 To the Fi	M	29b. Signature and the of certifier	29c. License number	7 290	Date signed (Month, E	(Say, Year)
		30. Name and address of pason who completed cause of death (Item 23a) (Type.	Anne Arm	del M	201100	(cnfr.
Regi	State strai		book			

State of Maryland / Department of Health and Mental Hygier (2) 15 1- State Registrar 2-18-05Amend #18.Per FH PCC cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death February 14, 2005 **Physician** Tyrone Alexander Wheeler 10:40 p M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center Clinton Prince George's 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Days Hours Months Min. 1**⊋**M 2□F 578-82-1739 63 Director Virginia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumstic event, the Madical Examinar must be notified at 10d. Inside City Limits MD Director Prince George's Oxon Hill 1 XYes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 5566 Livingston Terrace #302 20745 U.S. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other then "naturel", or Itel White, etc. Black 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Maintenance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Wright Naomi Smith Emma Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Gregory L. Wright-Brother 13516 Greencastle Ridge Terr., Burtonsville, MD 20b. Place of Disposition (Name of 20a, Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Importent: ff it any injury or o Mt Olive Baptist Chch 2-19-05 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Hot Springs, VA * 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 2504 28th St., N.E, WDC 20018 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 2 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by eq 1 ☐ Yes 2 ☐ No 3 Probably 4 Duknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a Was an page 2 certificate Division of Vital 1 ☐ Yes 21110 Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 🗌 Yes 2 100 Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours aft le Funerel Di letely filled in The printing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check onl To the within 2 one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Feburary, 15,05 50454 ddre of cerson who completed cause of death (Item 23a) (Type, Print) Sut 3-41 Silverspring MD Registrar

			1 - For State Registrar		State of I	Marylaı	-			Health and Death	Mental H	Reg. No	200	5	073	372
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ш	Director		214-26-8627	1 🗓 1	/ 2□F		77 Yrs.	Months	Days	Hours M	n. (Month, D ovember	a <i>y, Year)</i> 28 . 19	927 Ma	$\frac{Couint}{{ m aryla}}$	and	J
	pur		Usual Residence of Decedent 10a. State 10b. Coun	h/		10c C	ity, Town or Lo	nation								
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an	ld be ental ked c	To Be	Joseph			Wade	<u> </u>			Marv	Elizak		_	r. 70]]		
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at	permit. Pa Depertmen Impertant: any injury		21. Signature of Funeral Service	Licensee			22	. Name a	nd Addre	ss of Facility					-	
_	Dep dany	11	▶ Oclessa	21101		MO13					P.A. Ac		o, Ma	ryla	nd	
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rds, P	w requires that been signed b should be deta	by	Part II. Other significant condi	ions contri	outing to death	but not res	sulting in the u	nderlying o	ause givi	en in Part I.		obacco u Yes 2[se contribu	te to the		eath? Jnknown
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ĬŽ.	Physician: this certific ral director,	Be	25. Was case referred to medic examiner?		pital: ,				011		ath Check onl	one)				
of	Phys r this ral dir	- To	1 Yes 2 No		1 Unpa		ER/Outpatien 28b. Time of			er: 4 🗆 Nursing			Other (Specify)		
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	To the Hospital within 24 hours a To the Funaral I completely filled	edical	29a. Certifier 1 Certify (Check only one) 2 Medica	ng Physici Examiner	an: To the bes On the basis and manner:	of examina	owledge, death ition and/or inv	occurred estigation	at the tim , in my of	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) date and	and manne place, and	r as state due to th	ed. ne cause(s)	
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2	2 %		30. Name and address of person		leted cause of	death (Iten	n 23a) (Type, I	Print)						(
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	Sta Registr		FEB 1	7 200	5 2. 3018	war s Signa	turk A	perk								

			State of Maryland / Department of Health and Mo	ental Hygi	ene		
			1 - State Registrar Certificate of Death		g. No.2 ()	05	07373
	Physici		1. Decedent's Name (First, Middle, Last) Florence Genevieve Washabaugh	2. Date of Death Month February	י ז לא. 5	2005	3. Time of Death 9:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1001001	4c. County		5.00 11
			Calvert County Nursing Center Prince Frederick	_	Calve	ert Co	ountv
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birthpi Coun	lace (State or Foreign try)
	D		Usual Residence of Decedent	June 26,	1914	Penns	ylvania
	show	7	10a. State 10b. County 10c. City, Town or Location			10	Od. Inside City Limits
	the M	recto	MD Calvert County Chesapeake Beach 10e. Street and Number 10f. Zip Code	10	g. Citizen of \	What Coun	1 □ Yes 2 XNo
	h with	ID IS	4725 Willows Road 20732		U.S.A		.,,:
	ems ?	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent of Hispanic Origin? (Specific Forces) 15. Was Decedent Origin? (Specific Force	cify Yes or No- Rican, etc.)	14. Rac	ce - America	
36	filed within 72 hours after death with the Maryland Hygiene. sthar than "natural", or ttems 23e or 28e-f show ant. It e Madical Exemptive trust be modified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:	,	Specify		
21215-0036	72 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		6b. Kind of B	usiness/Ind	ustry
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5 0	filed v Hygie othar t	е Со	12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, M	Home	ne)	
<u>lan</u>	should be and Mental marked c	To Be	William Kerfoot Florence	e Pizzan	10		
Maryland	2 sho and h is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural		•		*
	1 and 2 Health tam 27		Allan Washabaugh (Son) 4725 Willows Road, Ches 20a. Method of Disposition 20b. Place of Disposition (Name of Day Day Day Day Day Day Day Day	ate 2	Beach, Oc. Location -		
JOE	Pages nent of I ant: If its		1 日本 Burial 2 Cremation 3 日 Removal from State 4 Donation 5 Other (Specify) Lafayette Mem。Park 2005	ary 21,	rier H		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "natural", or items 23e or 28e-f show any injury or other traumatic event. It a Modical Extending the realized and once.		21. Signature of Fungational Lice see 22. Name and Address of Facility Lee	Funeral	. Home	Calve	rt, P.A.
<u> </u>	\$2 E E 9	10 1	Michael W. Lee 8125 Southern Maryla	and Blvd	l., Owi		
П	45-1111		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	action	2	-	
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Вох	death dath d tor u	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes No		23d. Dat Mor	te of deliver inth	y Day Year
<u>Р</u> О	that the de led by the a detached t	hys	9 ☐ Unknown				
	ires tha signed d be del	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		1		bly 4 Unknown
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Re	The lay	Completed		autopsy performe	ed? p	prior to com death?	pletion of cause of
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of	F F E	P.	1 ☐ Yes 2 ₹ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home	e 5 Residen			
on	Attending I er death. ector: Atter by the tuner	atlon	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	ou. Describe now	rinjury occurr	BO	
N N	after deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Stre City or Town,	et and Numbe State)	er or Rural	Route Number,
Ω	pital o		Continue to Continue Disciplina Theorem				
	To the Hospital or A within 24 hours after To the Funeral Directory filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an and manner stated and place and manner stated.	nd due to the cau d at the time, dat	se(s) and ma e and place, a	inner as sta and due to i	ted. he cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number	290	d. Date signed	(Month, D	ey, Year)
			03312	>	Februa	ary 17	7, 2005
c	2		Jonathan D. Lowenthal, M.D. 110 Hospital Rd., #310, Pri	ince Fro	derick	MD	20678
Ĭ	Sta		31. Date filed (Month, Day, Year) 32. Registral's Signature	THE LIE	OCT TOY	رسيد و.	20010
	Registr	ar	FEB 1 8 2005 Novem & Sparles				

Please Type or Print in Black Indelible Ink Ensure

			r icas	State of Manua			•	3	•
			1 - For State Registrar	State of Maryla	•	nent of Health and cate of Death	, ,	2000	07071
		-	Registrar 1. Decedent's Name (First, Middle,	(act)	Certino	ale of Dealif	2. Date of Death	g. Ng. UU	U/3/4
	Physic /Medi	cal	Dora R.	edeboum	2/00V	ford	Februar	Day Yea	05 7:10 AM
	Exami	ner	4a. Facility Name (If not institution,	11 i		City, Town, or Location of D	eath	4c. County of De	ath 1
	Funeral				s. last birthday) If U	len Burnie Inder 1 Year If Under 24 H		Anne	irtholace (State or Foreign
ı	Director		388-22-6042	1□M 2XF 90	Yrs. Mor	nths Days Hours M	Min. (Month, Day, $July 6$,	Year) 1914 Wi	irthplace (State or Foreign Country) SCONSIN
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Location				10d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show roust be notified at	ector		Arundel An	napolis				1 ☐ Yes 2 No
	with t	ā	10e. Street and Number			f. Zip Code		g. Citizen of What (-
	heath w	era	1715 Woodlore Dr	12. Was Decedent Ever in		21401 Decedent of Hispanic Origin?		nited Sta	tes nerican Indian,
21215-0036	or its	by Funeral Director	1 Never Married 2 Marrie	Armed Forces?	43- If Yes,	ecedent of Hispanic Origin? specify Cuban, Mexican, Pues 2 No Specify:	verto Rican, etc.)	Black, Wh	White
5-0	"natural",	ted	15. Decedent's (Specify only highest		16a, Decedent's	Usual Occupation	1	6b. Kind of Busines	s/Industry
2	d within jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	if work done during most of the DT use retired)	working		
	e filed w Il Hygier other th	ဒိ	12		H	lome Maker		Own Home	e
anc	d be find H	Be	17. Father's Name (First, Middle, La UNKNOWN	IST/			Name (First, Middle, M	aiden Sumame)	
Maryland	2 shouk and Me is mark sumatic	ဥ	19a. Informant's Name/Relationshi	n (Type Print)	19h Mailing Add	UNKI Iress (Street and Number or	NOWN	City of Town Chair	To On to
Σ	permit. Pages 1 and 2 should be filed Depertment of Heelth and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, ang.	1	Katherine Cave /			dlore Drive	Annapolis,		
ē,	es 1 and 2 of Heelth I item 27 i		20a. Method of Disposition	20b.	Place of Disposition cemetery, crematory			Oc. Location - City o	
Baltimore	Page nent o nt: If		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe	LI TOTTO VALITORITO CIALO	kemont Mem	1	17/2005 Da	uri de anuri 1	lle,Maryland
alti	permit. Pag Depertment Important: any injury c		21. Signature of Funeral Service Li			e and Address of Facility		lar Funei	cal Home Inc
8	8978		1/16kg/	1 Am	147	Duke of Gloud	cester St.	Annapoli	s MD 21401
ì	Prrysician /Medical	11.00	23a. Part1. Enter the disease, or co shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that caused the dealth one cause in each line. a. Due to (or as a conse	iac Ar	mode of dying, such as card	diac or respiratory arres	it,	Approximate Interval Between Onset and Death
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Вох	ith cer tendir r use	A_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet.		ic pregnancy		23d. Date of de	livery
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Records,	quires n signe ald be	d by					1 ☐ Yes	_	robably 4 Unknown
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Re	The lav	Completed					 autopsy performe 	d? death?	utopsy findings available completion of cause of
Vital	certifice rector, p	0	25. Was case referred to medical			26 Place of D	eath (Check only one)	No 1 ☐ Yes	2 No
†	ysicle ils ceri direct	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	ER/Outpatient 3	Other	Home 5 Residence	e 6 Other (Spa	city I was a lit
n of	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how		i-ae.lil
sio	Attending ir death. octor: After by the fune	cati	2 Accident investigat 3 Suicide 6 Could not	he	М	1 ☐ Yes 2 ☐ No			
Division	after d Direct d in by	Certification;	4 Homicide determine		ome, farm, street, fac fy)	tory, office	28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	ledical C	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of my kno eminer: On the basis of examina	owledge, death occurration and/or investigat	red at the time, date and plaction, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as	stated.
	To the within 2 To the complex	Med	29b. Signature and title of certifier	and manner stated.		29c. License number		Date signed (Mont.	
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7		}	30. Name and address of person wh	o completed cause of death (Iter	n 23a) (Type Print)	0055	د ددت	114/05	
			1		100 hoch	Raven Blv	d Boltin	on mo	1218
	Sta		31. Date filed (Month, Day, Year)	32. Regionar's Signa	ature				-, -, -
	Registra	ar	FEB 1	6 2005	. At An	and a			

			For State Registrar		State of Ma	arylan		artmen rtificate				lental Hy	giene Reg. No	A	O 17	
	Dhamini		1. Decedent's Name (First, Mic	ldle, Last)								2. Date of De		C U	Year	3 Time of Death
	Physici /Medic		James	L.		W	elsh					Februa			005	6:50 P M
	Examin	er	4a. Facility Name (If not institut		reet and number)			, ,		Location	of Death		1	: County		
	-		Memorial Hosp 5. Social Security Number	ital 6.Sex	7. Ao	e (In vrs.	last birthday)	If Under		1and	24 Hrs.	8 Date of Bir		lleg		lace (State or Foreign
	Funeral Director		212-24-2234 Usual Residence of Decedent		4 200	5	Yrs.	Months	Days	Hours	Min.	8. Date of Bil Month, Di May 15	5, 19	29	Cour	MD
	Maryland f show	or	10a. State 10b. Cour MD Alle	gany		10c. Cit	y, Town or Lo Cumb		d						1	0d. Inside City Limits 1√□ Yes 2 □ No
	vith the l	Funeral Director	10e. Street and Number		Б.	. 0) 4/		10f. Zip		4500			10g. Ci	tizen of W		ntry?
	eath v	erai	13506 McKenz		Wer Road 2. Was Decedent			Was Doops		1502		acifu Vac or No		US 14 Page		an Indian,
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural; or items 23a or 28a-f ehow marked other than "natural; or items 23a or 28a-f ehow marked other than the molified at the Medical Example of the molified at the Medical Example of the molified at the Medical Example of the molified at the Medical Example of th	by Fun	1 ☐ Never Married ♣☐ M 3 ☐ Widowed 4 ☐ Divorce	arried	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		- 1	If Yes, spec		Specify:		ecify Yes or No Rican, etc.))- 	Blac	k, White,	etc.
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	ges 1 and 2 should t of Health and Men if item 27 is marks or other traumatic		19a. Informant's Name/Relatio	nship (Type	e, Print) wife		19b. Mailii 1350	ng Address 06 Mcl	(Street a Kenz	ie Ro	or or Aura ad	al Route Numb Cumb	er, City o perla	nd	State, Zip MD	21502
altimore,	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ②Crematio 4 ☐ Donation 5 ☐ Other		moval from State	C	Place of Disponentery, creametery, creametery	matory or o	ther place			Date 2/28/2005		esapt		wn, State
Baltii	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service		D (7 1 1	22	2. Name an	d Addres Irpelli	Funer	ăl Ho	me, PA				
	40240		23a. Part Enter the disease,	or complies	ations that caused	///	Do not ent					Cumber		MD 2	1502	Approximate
	Dhusisian		short, or heart failure. L	st only one	cause on each lin	ne.	n. Do not en	Doll ell le	e or ayırıç	, such as	cardiac	эт төэрпатогу а	irest,			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Non small cell lung cancer 3 Due to (or as a consequence of):												3 years	
	Examiner		Sequentially list conditions	b.	Hem		VISIS			,					F	ew days
	p t	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Įï		or as a consequente of):										a va Omys
	and and I-trans	Examiner	that initiated events resulting in death) Last	с.	Due to (or as	a consequ	nence of).								_	
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9	rtificate ng phys as the	Medi	IE ECHALE	-												
ВОХ	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	230	c. If yes, outcome 1□Live birth			⊒Ectopic pre	egnancy					23d. Date		*
0	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as f	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant at 9□ Unknown	time of de		Other (spe						Mon	itn	Day Year
J.	that the by detact		Part II. Other significant cond	tions contr	buting to death b	ut not resi	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco	use contri	bute to th	e cause of death?
Vital Records,	quires an sign uld be	ed by	COPD, At	rial	fibri	110-	tion					1 💢	Yes 2	□No	3 🗌 Probi	abiy 4 Unknown
၀ ၀	aw requir as been si 2 should	Completed										24a. Was		24b. W	/ere autor	osy findings available
Ĭ		Com										autor perfo	ormed? 2 No	di	eath?	npletion of cause of 2XNo
/Ita	sician: The certificate rector, pag	Be (25. Was case referred to media examiner?								of Death	Check only o				
0	Physi this o	7	1 ☐ Yes 2 No 27. Manner of Death	Ho	spital: 1 X Inpatia 28a. Date of Inju		ER/Outpatien			4 🗆 Nu	-	me 5 Resi)
ם	ding h h. After funer	tion	1 XNatural 5 ☐ Pend	ding stigation	(Month, Day	y Year)	28b. Time of Injury	M 20	Bc. Injury Work	at ? ′es 2∐1		28d. Describe l	now inju	ry occurre	90	
Division	al or Attendi after death. I Director: A d in by the fu	fica	3 ☐ Suicide 6 ☐ Coul	-	28e. Place of Inju	ury - At ho	ome, farm, str					28f. Location (Street ar	nd Numbe	r or Rural	l Route Number,
ā	s afte	Certification:	4 Homicide		building, etc	c. (Specify	V)					City or To	wn, State)		•
	To the Hospital or Attending Physician: within 24 hours atter death and To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only one) Certify	ring Physic al Examine	cian: To the best of or: On the basis of and manner sta	examina	wledge, death tion and/or in	occurred a vestigation,	at the time in my op	e, date and inion, deal	d place, a	and due to the ed at the time,	cause(s)	and mar d place, a	ner as stand due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certif	ier				29c	License	number			29d. Da	te signed	(Month, L	Day, Year)
			> Ana8	rail	u_{ℓ})			D463	46			FA	hri	100	28,2005
	'n		30. Name and address of person													23,2003
			Dr. Huma Shak		ohnson H			ical	RTg8	· Cı	ımbeı	rland,	MD	2150	2	
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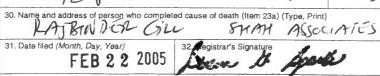
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician FEBRUARY 28, 2005** 5:30 A.M MARY VIRGINIA WOODWARD /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK EMMITSBURG 9119 WAYNESBORO PIKE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 ☐ M 2 🖾 F MARCH 12, 1919 EMMITSBURG, MD Director 189-09-6649 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County ul Hygiene, other then "neturel", or Iteme 23a or 28e-1 show ovent, the Medical Examiner must be notified al 1 ☐ Yes 2 ☑ No Director EMMITSBURG MARYLAND FREDERICK 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 9119 WAYNESBORO PIKE Completed by Funeral filed within 72 hours efter deeth 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HAIR DRESSER BEAUTICIAN 8 other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Heelth and Mental H lent: If item 27 Is marked other: EDITH M. RUARK GEORGE F. WINEGARDNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CAROL. A. KOONTZ/DAUGHTER 9119 WAYNESBORO PIKE, EMMITSBURG, MD. 21727 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of H Importent: If ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/3/2005 EMMITSBURG, MD. 21727 EMMITSBURG MEMORIAL * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fyneral Service Licensee SKILES FUNERAL HOME les 210 W. MAIN ST., EMMITSBURG, MD. 21727 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERY CARONARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Yes 2 No 3 Probably 4 Unknown DIABETES Be Completed EMPHYSEMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Tyes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2X No Medical Certification; To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the within 2 To the MO022239E 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GETTYS BURG 31. Date filed (Month, Day, Year)
MAR 0 3 20 2. Registrar's Signature State Spelle Registrar DHMH 17 Rev 1/2001

ORIGINAL

			Please T	ype or Print in Blac	ck Indelik	ole Ink.	Ensure All Co	pies Ar	e Legible.		
			For	State of Maryland /	Departme	ent of H	lealth and Menta	•	ne.	07077	
			Registrar		Certifica	ate of		Reg.	NZ 005	07377	
	Physic	an	1. Decedent's Name (First, Middle, Last)	E WATHER	N		Me		Day Year	3. Time of Death	
	/Medi Examir		4a. Facility Name (If not institution, give s			ity, Town, o	r Location of Death	RUARY	17 2005 4c. County of Deat	6:47 p M	
1	LXaiiiii	101	St. Mary's Hospital	·		Leonard			St. Mary's		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last b		der 1 Year	If Under 24 Hrs. 8. Da Hours Min. (M	te of Birth onth, Day, Ye ril 26,1	ar) 9. Birtl	nplace (State or Foreign untry) h Carolina	
	pu >		Usual Residence of Decedent	10-00-7							
	show ad at	2	u	5.00	wn or Location					10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	28a-f	Director	Maryland St. Mary's 10e. Street and Number	S Mecha	nicsville	e Zip Code		100	Citizen of Milhau Co.		
	ours after death with the Maryla rat', or Itams 23a or 28a-f shor Examiner must be maiffed at	10	41550 New Market Road		101.	20659		109.	Citizen of What Co	untry ?	
	death ms 2:	Funeral		12. Was Decedent Ever in U.S.	13. Was De	cedent of H	ispanic Origin? (Specify Ye	es or No-	r No- 14. Race - American Indian,		
9	after or Ital	교	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 No	If Yes, s	pecify Cuba	in, Mexican, Puerto Rican,	etc.)	Black, White	e, etc.	
93	ours iral',	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 L Yes	2 X No	Specify:		Specify: Whi	te	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23a or 28a-1 show ant, the Medicel Examirer must be natified at	Completed	15. Decedent's Educ (Specify only highest grade		. Decedent's U (Give kind of	work done	during most of working	16b	. Kind of Business/I	ndustry	
12	withir ane. than	E C	Elementary/Secondary (0·12)	Homemal		1)		Own Home			
	2 should be filed within 72 hours after death with the Mand Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f. Is marked other than "natural", or Itams 23a or 28a-f.	Be Co	17. Father's Name (First, Middle, Last)		пошена	KCI	18. Mother's Name (First,				
Maryland	lid be fental rked ic ev	To B	John Frank Slade				Maude Isabell	Rawls			
ary	shou and N		19a. Informant's Name/Relationship (Type	oe, Print) 19	b. Mailing Addre	ess (Street	and Number or Rural Route		y or Town, State, Z	ip Code)	
	and 2 saith n 27 i		Teresa Ann Wood/Daughte	er 41	550 New 1	Market	Turner Rd., Med	hanicsv	ille, MD 2	0659	
ore	of He of He If item or oth		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ R	camata	of Disposition (A	Name of or other place	Date	20c.	Location - City or 1	Town, State	
Ë	Pag tment tant: jury c		' 4 ☐ Donation 5 ☐ Other (Specify)	Sacred	Heart Co	emetery	Feb 22,200	5 Bu	shwood, Mar	y1and	
Baltimore,	permit. Pages 1 and 2 should b. Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic e once.		21. Signature of Funeral Service License	-HI			ss of Facility Cardiner Funeral	Home.	P.A. P. O.	Box 270	
			23a. Part1. Enter the disease or complic	tations that caused the neath. Do	Leonar	rdtown,	MD 20650	_		Approximate	
	Dharaistan		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.			20 CH CHAMY		se !	Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence		100 1		71(0)		YEARC -	
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	and transit	aminer	Cause (Disease or injury that initiated events resulting in death) Last								
68760,	flicate be exec g physician an ts the burial-tr	EX	resulting in death) Last	Due to (or as a consequence	of):						
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X 6	The law requires that the death certificate be exe tle has been signed by the attending physician ar page 2 should be detached for use as the burial-	Physician/Medical	IF FEMALE:	3c. If yes, outcome of pregnancy					Old Date of delle		
Box	atter d for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death	3 ☐Ectopic 5 ☐ Other				23d. Date of deliv Month	Day Year	
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	es that igned to be det	by P	Part II. Other significant conditions con	tributing to death but not resulting i	in the underlying	g cause give	en in Part I. 23		o use contribute to		
ord	w require been sig should b		7147	MBAILLATIO	<i></i>			1 Ves	2 □ No 3 □ Pro	bably 4 □Unknown	
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æ		Con					1	performed? Yes 2	death?		
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	a anitali		0.1	26. Place of Death (Chec	k only one)		_	
of	hys his	2	1 Yes 2 No	TO COMPANY OF THE PARK OF THE	utpatient 3 1		4 Nursing Home 5			fy)	
O	ng fter ine	ertification:	1 Natural 5 ☐ Pending		Time of Injury M	28c. Injury Work	rat 28d. De t? Yes 2∐No	escribe how in	lury occurred		
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Di	alor/ s after N Dira	Serti	4 Homicide	building, etc. (Specify)		,,	Cit	y or Town, Sta	ate)		
	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	ledical C	29a. Certifier (Check only one) (Check only one) (Check only one)	ician: To the best of my knowledger: On the basis of examination are and manner stated.	e, death occurre nd/or investigation	ed at the timon, in my op	e, date and place, and due pinion, death occurred at th	e to the cause te time, date a	(s) and manner as s and place, and due t	stated. o the cause(s)	
	To the within 2 To the Comple	Me	29b. Signature and title of sertifier		2	29c. License	number	29d. [Date signed (Month,	Day, Year)	
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State Registrar



HOLYWOOD

20636

MD

			1 - For Ragistrar	State of M	larylan		artment of I				000	in trus	0 22 0
		i	Decedent's Name (First, Middle, Last				inicate or	Death		. Date of Deat		3	3. Time of Death
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	Examir		4a. Facility Name (If not institution, give	street and number	?		4b. City, Town,	or Location o			4c. County of		
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	Funeral		5. Social Security Number 6. Se	x 7.A XIM 2□F		last birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day,	Year)	Birthpla Countr	ice (State or Foreign
	Director		214 - 34 - 1442 Usual Residence of Decedent		68	115.			S	ept. 22	2, 1936	Ma	ryland
	/land		10a. State 10b. County		10c. City	y, Town or Lo	cation					100	d. Inside City Limits
	Marf st	ţo	MD Garret	:t			0ak1	and					1 ☐ Yes 2 ☒ No
	or 28)ire	10e. Street and Number				10f. Zip Code	-		10	0g. Citizen of Wh	at Countr	y?
	death with the Maryland ms 23a or 28a-f show Litusi be rivilled at	ral	64 Bucks Run Road				21	550			Ţ	JSA	
	er de	Funeral Director	11. Marital Status	Was Decedent Armed Forces'	?	S. 13.	Was Decedent of H f Yes, specify Cub	lispanic Orig an, Mexican,	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	14. Race - Black.	American White, et	
36	hours after tural', or Ite	γF	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 ☐ If Yes, Give Year or Dates:	No		Yes 212 No	Specify:			Specify:		ite
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yla	ould Man Marka Marka Marka Marka	ဥ	John Willia		Wilso			Mary		C1eme		Mos	
Maryland 21215-0036	and 2 should be alth and Mantal 27 is marked of ar traumetic even		19a. Informant's Name/Relationship (Ty Ruth J Wilson/Wi				g Address <i>(Street</i> ucks Run						ode)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mantal Hygiene if Health and Markal Hygiene is the filem 27 is marked other than "natural", or thems 23a or 28a-f show other traumatic event, the Medical Examinan transite anothing a		20a. Method of Disposition		20b. P		sition (Name of	Roau,	Date		20c. Location - Cit		n Stato
<u>o</u>	ages ant of it: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	CE	emetery, cren	natory or other plac	1	2/24/				
Baltimore,	permit. Pages 1 a Department of Hea Important: If item any injury or otha <u>once</u> .	1	21. Signature of Funeral Service License	ee \	Ome		matory Name and Addre				Morgant		
ñ	permit. Departr Imports any inji		> Brown 1	(Street)			ewart Fu				32 S. Se 0ak1and,		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that couse	the deeth					spiratory arre	st,	A	pproximate
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8760,	icate be axecutad physician and s the burial-transit	dicai		1									
99	tificat ig phy as th	led i											
Вох	death cartific attending p	2	200. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy				23d. Date o	f delivery	
. E	the att	Sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at			Other (specify)				Month	Da	y Year
P.0	that the diad by the detached	Physician/Me	9 Unknown			44							
ds,	8 <u>5</u> 9	þ	Part II. Other significant conditions con	ithouting to death b	ut not resu	iting in the un	derlying cause givi	en in Part I.			acco use contribu	,	
Records,	baen s	Completed							-			Probab	
Rec	helav shas ge 2:	du.							-	24a. Was an autopsy perform	prior	ta comp	findings available letion of cause of
			25. Was case referred to medical						(5) (5)	1 ☐ Yes 2	2No 1	Yes 2[□ No
>	rnysician: this certific ral director,	0	eyaminer?	ospital:	ent 2∏F	R/Outpatient	3□ DOA Othe			heck only one	ce 6 ⊡Other (Canaifal	
	ding Phys h. After this funaral di	ë	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Injury Work	at			injury occurred	эрөспу)	
<u>.</u>	death. ctor: Af y tha fu	ät	1 Accident 5 Pending investigation	(, , , ,	,		Yes 2 □ No	0				
Division	i or Attending after death. Director: After I in by tha funai	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, et	ury - At hor c. (Specify)	me, farm, stre	et, factory, office		28f.	Location (Stre	et and Number o State)	r Rural R	oute Number,
	urs al								_4				
	io the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	er: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred at the time estigation, in my op	e, date and pinion, death	place, and occurred a	due to the cau t the time, dat	ise(s) and manne e and place, and	r as state due to the	d. e cause(s)
:	o the		29b. Signature and title of ceptifier	and marinor ste			29c. License	number		290	d. Date signed (M	onth, Day	/, Year)
	->=0		Miller	Man-		MI	000	025	750	1		-	
	MA	-	30. Name and address of person who con	mpleted cause of d	eath (Item :	23a) (Type, P	POBOX2		-	1 60	Draniy 2	1.60	161
8	ku,	(44)	Walter K. No	aumani	n pu.	D. ,	POBOX2	47, 1	Accid	dent	MD213	-20	>
	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu		-						

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment o			d Mental F	lygien Reg. N	- U U U	07379
	Physici		1. Decedent's Name (First, Middle, La	st)					2. Date of Month		ay Year	3. Time of Death
	Physici /Media		RODDY	W	Ţ.	JILLIAM	IS		JAN		2005	8:25 P M
	Examir	ner	4a. Facility Name (If not institution, giv	e street and number)	4b. City, To			eath	4	c. County of Dea	th
			NATIONAL NAVAL M				THES					GOMERY
	Funeral Director		109-34-0300	ex 7.A XΩM 2□F	ge (In yrs. last binthday) 61 Yrs.	Months D		f Under 24 H Hours N	Irs. 8. Date of Month, Feb.	Birth Day Year	943 P	thplace (State or Foreign cuntry) enn.
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation						10d. Inside City Limits
	Mary	jo	VA Fai:	rfax	Rest	on						1 XYes 2 □ No
	28a	Director	10e. Street and Number			10f. Zip Co	ode			10a. C	itizen of What Co	ountry?
	3a or	D	1636 Valenc	ia Way			2	0190			U.S.A.	,
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Examirer must be mailfied at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Deceden	t of Hisp	anic Origin?	(Specify Yes or lerto Rican, etc.)	No-	14. Race - Ame	
9	after or Ite	Fu	1 Never Married 2 Married	Armed Forces	No 196 / -				ierto Hican, etc.)		Black, Whit	
8	raf',	1 by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1979	1⊡Yes 2√∑	INO '	Specify:			Specify:	Black
ر ا	d within 72 hours Jiene. r than "natural",	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual C	done dur		working	16b. l	Kind of Business	Industry
121	within ene. than	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOTuse i Iilita	,	/Po+	rodl	7.7	c corr	ernment
2	a filed withli I Hygiene. other than rent, It e M		17. Father's Name (First, Middle, Last)	2 yrs	1	ııııca	-		Name (First, Midd			ermenc
and	d be filed ntal Hyg ed othe avent,	Be	Buck Will				10	s. Mother's	Minni Minni			
Š	should be nd Mental marked o	2	19a. Informant's Name/Relationship (19h Maili	ng Addross (C	Person t and	Alumbara			or Town, State, 2	7-0-4-1
Z	d 2 s th an th an trau		Carolyn Willia	** *								
ō,	Heal Heal tem		20a. Method of Disposition	allis daug	20b. Place of Dispo	sition (Name	of	La Wa	y, Rest		VA 20	0 1 9 0 Town, State
<u>o</u>	ages ant of tr: If it		Marial 2 ☐ Cremation 3 ☐ `4 ☐ Don• in 5 ☐ Other (Specified)		emetery, creater	-	. ,	Com	2/17/05			
Baltimore, Maryland 21215-0036	artme orten injur		21. Signature of Funeral Service Licer	V /		2. Name and A						
ä	permil. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic as once.		Leonge &	ν 1		46 N	Ma	chino	showae	пто	nerar	Home, P.A
			23a. Part1. Enter the disease, or dom shock, or heart failure. List only	lications that cause	d the death. Do not en	ter the mode o	of dying, s	such as card	liac or respiratory	arrest,	COCKVII	le MD
	Physician		Immediate Cause (Final		iii e.							Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)		JKEMIA s a consequence of):							
	Examiner		O a servicio di a di a servicio di a	b	,							
	T .==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		s a consequence of):							
	nd trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c								
0,	oe exe		resulting in death) cast	Due to (or as	a consequence of);							
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai		d								
ဖ	death certifica attending pl	/Me	IF FEMALE:	220 Hugo outcome								
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregr					23d. Date of deli Month	very Day Year
O.	that the de ed by the detached	Physician/Me	1 Yes 2 No 9 Unknown	9□ Unknown	at time of death 5L	Other (special	<i>IY)</i>			-		
ص ّ	res that the signed by be detacted		Part II. Other significant conditions of	ontributing to death t	but not resulting in the u	nderlying caus	se given i	n Part I.	23e. Dio	tobacco	use contribute to	the cause of death?
rds,	requires that the een signed by th nould be detache	d by							10	Yes 2		obabły 4 🗆 Unknown
of Vital Record	> 4	Completed							24a. Wt	as an	24b. Were au	topsy findings available
æ	0 C 0	E O							- au	topsy rformed?	prior to death?	completion of cause of
ta	ician: Th certificate ector, pag	e e	25. Was case referred to medical				26	8 Place of I	1 ☐ Yes Death (Check only		1 ☐ Yes	2⊠ No
<u>></u>	Physician: this certific ral director,	0 B	examiner? 1 ☐ Yes 2 ☐ X Vo	Hospital:	ent 2 ER/Outpatier	at 3 DOA	Othor				6 ☐Other (Spec	rific)
	g Ph	n:	27. Manner of Death	28a. Date of Inju	ury 28b. Time o		Injury at Work?		28d. Describ			ally)
<u>o</u>	Attending I r death. ector: After by the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year) Injury	м		2 🗆 No				
Division	or Attencater death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of in	jury - At home, farm, str tc. (Specify)	eet, factory, of	ffice			(Street a		ral Route Number,
ā	ital or rs afte ral Dir led in l			201101119, 0	to. (Speeny)				Ony of t	own, otal	0)	
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1	y sician: To the best niner: On the basis of and manner st	of my knowledge, death of examination and/or in tated.	n occurred at t vestigation, in	he time, my opini	date and pla on, death or	ice, and due to the courred at the time	e cause(s e, date an	and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/		29c. Li	icense nu	ımber		29d. Da	ate signed (Month	, Day, Year)
•	1) /ah	-12	mn	2	2114	(AL)		FEX	BRUVAN	01,85
	>		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print)		NATIO	NAL NAVA	L MEI	DICAL CE	NTER
			JONATHAN C. GROP	LCDR_M	IC USN			BETHE	SDA MD 2	0889-	-5600	
760	Sta	200	JONATHAN C. GROE 31. Date filed (Month, Day, Year) FEB 1 6 2	nns 32. Zegisti	rar's Signature	rele						
9-	Registr	аг	1 EO T () C	JOHN COME	10 15 PM	- 9000						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Amend Item 1 p	er Dr.,G82	11,0370	3/U5db Certif	b icate of l	Death		Reg. No.	15 0	7380
	Discouries a		1. Decedent's Name (First, Middle, L	aka _ E]	lisabe		elton	Brown	2 Date of De		Year 3	. Time of Death
	Physicia /Medic		E'll Subeth (ove Bro				220	2	12	05-1	1050pm
<i>)</i>	Examin		4a Fecility Name (If not institution, gi	ve street end number)			4	lb. City, Town, or I	Location of Deat	1	1	
			Williamsport	Retwent	TUIL	uge	L	William	SONT	Was	anstor)
П	Funeral		*	Sex 7. Ag 1 M 2 TxF	e (In yrs. last b	D.A.	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthplace Country)	(State or Foreign
	Director		232-26-1750 Usuel Residence of Decedent	X.		TIS.			APR 26	, 1918	West V	irginia
	and **	1	10a. State 10b. County		10c. City, Tox	wn or Location	on				10d.	Inside City Limits
	d sho	ō	MD Wash	ington	н	agers	town					1 ☐ Yes 2 ဩ No
	28e	Director	10e. Street end Number				Of. Zip Code			10g. Citizen of V	What Country?	
	ter deeth with the Marylan tems 23a or 28e-f show Ingr. must be notified at	<u>ā</u>	18931 Manches	tor Drive				21742			USA	
	deeth	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was	Decedent of H	ispenic Origin? (S In, Mexican, Puert	pecify Yes or No		e - American I	ndian,
0	or its		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ X					o Rican, etc.)		ck, White, etc.	
Š	el', o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		10	Yes 2 X No	Specify:		Specify	" Whit	e
Maryland 21215-0020	n 72 hours efter deeth with the Maryland "natural", or frems 23a or 28a-f show sideal Examiner must be notfled at	Completed	15. Decedent's E (Specify only highest gi		168	a. Decedent	s Usual Occupa	ation	kina	16b. Kind of Bu	usiness/Indust	ry
7	within ene. than "	흔	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO I	VOT use retired	during most of wor ()	ng			
2	TO CO. L.	S	12	4		Ноп	emake				mestic	3
ng D	8 ± 5 ≥	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Nan	ne (First, Middle	, Maiden Sumam	16)	
3	should be nd Mentel marked o imatic eve	2	Harry C. Wel						J. Pa			
ā Z	어 ⁶ 학 학 ·		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing A	ddress (Street a	and Number or Ru	rel Route Numb	er, City or Town,	State, Zip Cod	de)
	s 1 and f Heelth fem 27 other t		Thomas Brown 20a. Method of Disposition	- Son	20h Place	L1415 of Dispositio	Weather	stone Dr	Date			
Baltimore,	8 2 = 5		1 ☐ Burial 2 ☐ Cremation 3 I		cemete	ery, cremato	ry or other plac			20c. Location -		
Ħ	nit. Peg ertmant ortant: ii Injury o		4 Donation 5 Other (Spec		Omps		tion Se		2/14/05	Winc	hester.	, VA
Ba	Depe mpo mpo mpo my l		21. Signature of Funeral Service Lice	insee		Fr	me and Addres	Funeral	Home			
			Duan	Smith		14	15 N.	Main St	., Moo	refiel	d, WV	26836
4 - 4			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each li	the death. Do ne.	not enter th	e mode of dyin	g, such as cardiad	or respiratory a	rrest,	Inte	proximate erval Between set and Death
	Physician /Medical		Immediate Cause (Final	0.1	6.1				0		-	
	Examiner		disease or condition resulting in death)	a. Chroms	c 06	struct	rive P	ulmonar	4 19-13	ease	5	YEARS
		ē			Due to (or as a	consequen	ce of):		1		!	
	nsit 1	Examine		b	Ph. 1 - 5							
Ć,	exac n an ial-tr	EXS	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a	Consequen	ue oi).				1	
68760,	death certificate ba exacuted e ettending physician and ed for use es the burial-tr nsit	edical	that infliated events	C	Due to (or as a	consequent	se of):	77.77			-	
89	ing phy e es th	Med	resulting in death) Last			001100400110					1 2 1	
Вох	eath cer ettendin for use	2	•	d								
<u>.</u>	as thet tha death ce igned by the ettendi be detached for use	by Physician/I	Part II. Other significant conditions	contributing to death b	ut not resulting	in the under	lying cause give	en in Part I.	23b. Did	tobacco use co	ntribute to the	cause of death?
P. 0.	by the	چ	Diabetes M	ellitus					1 🗆	Yes 2□ No	3⊠ Probabl	y 4 Unknown
	as the	<u>Ā</u>	DICIBETES III	-101 7005								
of Vital Records,	Tha law requiras thet tha ata has been signed by th paga 2 should be detache	Completed							24a. Wes	an autopsy	24b. Were a availab	autopsy findings ole prior to
S	alaw re hasbe ga 2sh	pie									of deet	etion of cause th?
<u> </u>	Tha is ata ha paga	ĕ							10	Yes 2 No	1 □ Ye	s 2□ No
ita ita	ysician: The is cartificata director, par	Be (25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)		
<u> </u>	SOD	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	ent 2 ER/O	utpatient 3	DOA Oth	er: 423 Nursing H	ome 5□ Resi	dence 6 □Oth	er (Specity)	
טע	ding P1 h. After tt funera		27. Manner of Death 1 ☑Naturel 5 ☐ Pending	28a. Date of Inju (Month, De	ry 28b.	Time of Injury	28c. Injun Worl	y at k?	28d. Describe	how injury occur	red	
Sio	Attending or daath. Cotor: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not				M 10	Yes 2□No				
Division	offer daath Oirector: / d in by the	Certification:	4 Homicide determine	28e. Place of Inj building, et	ury - At home, f c. <i>(Specify)</i>	farm, street,	factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural Ro	oute Number,
	oral C	S										
	Hospital 24 hours Funeral stely fillad	edicai	29a. Certifier (Check only one) 1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of	f examination a	je, death occ nd/or investi	curred at the time gation, in my of	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	anner as stated and due to the	d. cause(s)
	To the Hospital or Attending Phywithin 24 hours effer dasth. To the Funeral Director: After this completely filled in by the funeral	Mec	29b. Signature and title of certifier	end manner sta	aldu.		29c. License	e number		29d. Date signe	d (Month Dav	Yeer)
	F ≱ F 8		1806,00	110			1000	3700				
		-	30. Name and address of person who	completed source of d	looth /Itom (CC-)	(Tune Dele		> 100		Februan	115,	2005
	10		TED HOWE, MD		PETIZA			_1 AM3PO	ET. MI	7	1795	
	°Sta	te	31. Date filed (Month, Day, Year)		er's Signature	9 31	, , , , , ,		~ () () () ()			
	Registr		MAR 0 3 2005	Marian	H do	sale)						

ORIGINAL

DHMH 16 Rev 6/95

	1	For State Registrar	State of N		nd / Depa		t of H	ealth a		ental Hyg		05	0738
		1. Decedent's Name (First, Middle, L	ast)							2. Date of Deat Month	1 Day	Vans	3. Time of Dea
Physician /Medical	_	Howard Victor Zi	mmerman							February		Year 2005	6:00 A
Examiner		4a. Facility Name (If not institution, gi	ve street and numbe	or)		4b. City,	Town, or	Location o				ty of Death	_ 0.00 h
		642 Grant Place				F	rede	rick			Fr	ederi	ck
Funeral Director		5. Social Security Number 6. 214-10-5588	Sex 1 M 2 □ F	Age (In yrs. 8 7	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth Dec. Pay.	^r 1917	9. Birthi Mary	place (State or Foi Pand
2 200) <u> </u>	Usual Residence of Decedent 10a. State 10b. County		100 Ci	ty, Town or Lo	ontion							104 1-14-00-11
natural, or Items 23a or 28a-1 show iteal Examination in titled at eted by Funeral Director	1.	Maryland Freder:	ck		ederic								10d. Inside City Lin
al, or items 23a or 28a-1 s rain retrinust be notified by Funeral Director		10e. Street and Number 642 Grant Pla	ace			10f. Zip 21	702			10	U.S.A		ntry?
ems frai	5	11. Marital Status	12. Was Decede Armed Force		J.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. Ra	ce - Americack, White,	can Indian,
al', or Ite	2	1 ☐ Never Married XXMarried 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Date:	ĮΝο	i	1 Yes		Specify:	, 1 00110 2	aloun, oto.,		ack, while, ity:Whit	
'natur dical		15. Decedent's I (Specify only highest g			16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa	ation luning most	of working	ng	6b. Kind of	Business/In	dustry
ygiene. her than "natura it. the Wedical E	2	Elementary/Secondary (0-12)	College (1-4c	r 5+)	Maint		_				Public	Scho	ool Syste
d other event.	5	17. Father's Name (First, Middle, Las	t)					18. Mother	r's Name	(First, Middle, N	laiden Surna	me)	
Mental narked natic ev	2	Howard Vic		erman,						e Belle			
n 27 Is n er traun		19a. Informant's Name/Relationship Mrs. Virginia E	. Zimmerma		ife 64	2 Gra	ant I	lace,	Fre	ederick,	MD 21	n, State, Zip 2702	o Code)
penitr. Tages 1 and 2 should be med which 72 hours are locating the way as Department of Health and Mental Highene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at 20ce. To Be Completed by Funeral Director		20a. Method of Disposition †⊠Burial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Spec		Res	Place of Dispo cemetery, crei thaven M	natory or o	ther place	dens :		28, 2005	oc. Location Fred	· City or To lerick	
Departr Importa any inju		21. Signature of Funeral Service Lice	Drod	M002	255 1	Keene 06 Ea	d Addres By ar	id Bas Church	ford	l PA Fun , Frede	eral H rick,	Home MD 2	21701
hysician		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	ed the dear line. Imphys		er the mod	e of dying	g, such as o	cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death 20 Yrs.
/Medical Examiner		resulting in death)	Due to (or	_									
in and rial-transit	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consec	quence of):								
D Cicio		that initiated events resulting in death) Last	c. Due to (or a	as a consec	quence of):						_		
			d										
ar of the	The state of the s	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	al death 3	Ectopic pro					1	ate of delive	ery Day Year
be od vd	ן י	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying ca	ause give	n in Part I.					ne cause of death
been signature been signature belong the second the sec	-									1A Ye	2 U No	3 Prob	ably 4 Unkno
page 2	-									24a. Was an autopsy perform 1 Yes 2	ed?	prior to con death?	psy findings availampletion of cause
certificate rector, pag)	25. Was case referred to medical examiner?					_	26. Place	of Death	(Check only one			
this certificated director.		1 ☐ Yes 2X No			ER/Outpatien	t 3 DO	A Othe	E 4 □ Nur	sing Hom	ne 5X Resider	ice 6 Ot	her (Specify	y)
r death. by the funeral director, filcation; To Be C		27. Manner of Death 1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of ir (Month, I	jury Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y	at ? ′es 2 □ N		8d. Describe hov	v іпји гу осси	rred	
rs after death. al Director: After ted in by the funera		3 Suicide 6 Could not 4 Homicide determined	28e. Place of	njury - At h etc. <i>(Specit</i>	ome, farm, str 'y)	eet, factory	, office		2	8f. Location (Street) City or Town,	et and Num State)	ber or Rura	l Route Number,
within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification:		29a. Certifier 1	hysician: To the bes miner: On the basis and manner	of examina	owledge, death	occurred a restigation,	at the time in my op	e, date and inion, death	place, a	nd due to the car d at the time, da	use(s) and m e and place,	anner as st	tated. the cause(s)
To the comp		29b. Signature and title of certifier	7			29c	License				d. Date signe		
17		1 viteus	Liurry				D 09	9689		F	ebruai	y 25,	, 2005
10		30. Name and address of person who Austin Pearre					eet,	Free	derio	ck, Mary	land 2	21701	
State Registrar		31. Date filed (Month, Day, Year) MAR 0 3 200	2. Regis	trar's Signa	ture								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ACKERMAN IV GEORGE MARCH 2005 01 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death mariner Catonsville ealth atonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 218-36-0427 1**X**M 2□ F Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. tnside City Limits Baltimore Baltimore 1 □ Yes 2 No Marylana 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3100 21222 12. Was Decedent Ever in U.S. Armed Forces? 1) MYes 2 □ No WYes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT, use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ler 17. Father's Name (First, Middle, Last) t8. Mother's Name (First, Middle, Maiden Sumame) Ackerman, III Margaret Alverta + rancis (\$\int 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Catonsville Hillsid 'e 10 iclanne A 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other Evans tuneral `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 21093 Enter the disease, or conforcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN CANCER METASTATIC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TUMOR SUSPECTED PRIMARY LUNG 7UN PLS EA 244. Was an autopsy performed was 20 1 ☐ Yes 2 ☐ No 3 ☐ Probably OBSTRUCTIVE PULMONDRY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner Examiner as the burial-transit The law requires that the death certificate be executed Physician/Medical esn P.0. ρ Records, Be Completed Division of Vital the Hospital or Attending Physician: After death. after death

Physician

/Medical

Examiner

Director

Completed by Funeral

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Department of Health and Me-Important: If Item 27 1-any injury or con-

other treumetic event, the Medical Examiner must be notified at

be filed within 72 hours after

Baltimore, Maryland 21215-0036

Certification: To 29a. Certifier

n 24 hours at Medical within 2 To the

29b. Signature at

(Check only one)

29c. License number 2723

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) MARCHOI 2005

30. Name and address Arson who completed cause of death (Item 23a) (Type, Print) 5310

AYYERAKTALLI M HARISH REF

RORS, SUITE 303 OLD CON RT RAMPALLSTOWN

31. Date filed (Month, Day, Year) State MAR 0 7 2005 Registrar

2. Registrar's Signature

Grawn, Catherna

1 - For State Registrer

Physician

/Medical

Examiner

Registrar DHMH 17 Rev 1/2001 1. Decedent's Name (First, Middle, Last)

Charles Edward Beckwith

4a. Facility Name (If not institution, give street and number)

		Sinai Hosp	ital of	1300	CAM	v) If Under 1 Year	If Under 24 Hrs.			ere City
Funeral Director		213 70 7731	□M 2□F	64	last birthda Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Y	(ear) 9.86 1940	rthplace (State or Folggn ountry) Maryland
and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or	Location			<u> </u>	10d. Inside City Limits
e Maryl la-f sho liffed a		Maryland Balti	more	V	lood.	Lawn				1 ☐ Yes 21X No
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s 1 and 2 should be filed within 72 hours after death with the Maryland free trans 23 and 2 should be filed within 72 hours after 33 and 28a-f show item 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Wedtal Examination traust be notified at To Be Completed by Funeral Director	Dy I wild	11. Marital Status 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent & Armed Forces? 1 Yes 25 N If Yes, Give Year or Dates:		S. 1:	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Specian, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi Specify 1 a	te, etc.
ed within 72 hou ygiene. ner than "nature t, the Wedfeal E	ובוכה	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>		(Gi	cedent's Usual Occup ve kind of work done . DO NOT use retire	during most of working	7	b. Kind of Business	/Industry
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s 1 and 2 sho f Health and I item 27 Is me other traums		19a. Informant's Name/Relationship (7 Lisa Alden/ Car		ler	The 721	iling Address (Street Arc of 5 York R	Baltimore oad Balt:	Route Number, C E imore . M	City or Town, State,	Zip Code) 21 21 2
eg ≟ ≒ io		20a. Method of Disposition 1√2 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	a	lace of Dis	position (Name of rematory or other pla	. Da)5 ²⁰	c. Location - City or	
permit. Pages 1 at Department of Hea Important: If item any Injury or other		21. Signature of Funeral Service Licens	Sey		5		ess of Facility Char eterstown			neral Home Md 21215
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/Medical Examiner		disease or condition resulting in death)	a. Due to (or as			5 tinal	Bleed	ing		
je je	101	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	uence of):	ancer				
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he death cert the attendin hed for use	ysicializment	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	I death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
		Part II. Other significant conditions co	ontributing to death be	ut not resu	ulting in the	underlying cause gr	ven in Part I.			o the cause of death?
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vician: icanifical certifical rector, p	ע	25. Was case referred to medical examiner?					26. Place of Death			
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In Attending I after death. Director: After I in by the funer	arion a	1 KNatural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Da)	y Year)	Injur	y Wo	nyat 28 nrk?]Yes 2 □No	3d. Describe how	injury occurred	
tal or Attending Physician: rs after death. all Disector: After this certification by the funeral director. Certification: To Be C	Ser Her	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At ho c. (Specif)	ome, farm,	street, factory, office	28	Bf. Location (Stree City or Town,		ural Route Number,
To the Hospital on Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu Medical Certificati	alcal	29a. Certifier (Check only one) 12-Certifying Ph	ysician: To the best of ainer: On the basis of and manner sta	f examinat	owledge, de ition and/or	ath occurred at the tr investigation, in my	ime, date and place, ar opinion, death occurred	nd due to the caused at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
To the within To the Comp		29b. Signature and title of certifier Ali Bar	al M	7,)		29c. Licen:	se number	İ	Date signed (Mon	th, Day, Year) 2005
H		30. Name and address of person who	-	ieath (Item	n 23a) (Tyr	pe, Print)	1 /3	Poltin	1000	Masyland

MAR 0 7 2005

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death Month

02

Day

26

Year

2005

Baltimore

4c. County of Death

1:20 PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Christa Bell Brooks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV . 2, 1921 9. Birthplace (State or Foreign Country) N. Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M X XF Yrs. 213-20-9539 Director Usual Residence of Decedent be filed within 72 hours enumeral Hygiene.
and other than "natural" or items 23a or 28a-f show set other than "natural" or items 23a or 28a-f show set other than "natural" or items 20 or cellified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Maryland Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 2142 Penrose Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 💥 No Specify: þ 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th grade Homemaker Own Home t. Pages 1 and 2 should be filed virtuent of Health and Mental Hygie rtent: if item 27 is marked other thury or other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roy Rawlins Eva Laughinghouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 Rushon Brooks/ Son 12 Slate Mills Ct. Catonsville, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Crownsville Vet. Cem. 0 - 051 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. Crownsville, Md * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Paneral Service Livensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltomore, Md 21215 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart allure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final is ase or condition resulting in death) Pnysician neumonia /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause of fright that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Day Month 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed) 1 Yes 2 No 212 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient P 1 Yes 2 No 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ within 24 hours aff To the Funeral Di completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 16894 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar AMJAD RIAR

31. Date filed (Month, Day, Year)

32. R

Baltimore

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			for State	State of Marylan				-	2.0	05	07206
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	Physici		Raymond A. Br					Month	Day	05 Year	10:20a M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of De			nty of Death	
			7804 Wynbrook	Road					/a Ba	ltimo	re
	Funeral		5. Social Security Number 6. S 214-14-0113	ex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours M	1rs. 8. Date of Bin (Month, Da 8 – 1 0 – 1	th y, Year)	9. Birthp	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	02	113.			8-10-1	922	Balt	tímore, MI
	ryland how		10a. State 10b. County	ltimore 10c. Cit	y, Town or Lo	ocation				1	10d. Inside City Limits
	Be-f s	cto		relimore							1 Yes 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is merked other than "natural", or items 23a or 28e-f show or other traumatic event, the Madical Examinat must be notified at	Funeral Director	10e. Street and Number 7804 Wynbrook	Road		10f. Zip Code 2122	4		10g. Citizen o	of What Cour	ntry?
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ထ္ထ	or ite		1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No WW If Yes, Give	TT	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		ierto Rican, etc.)		Black, White,	
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Mar	nd 2 sh lith and 27 is rr r traum		19a. Informant's Name/Relationship (Mary Trotta	Type, Print) niece				Rural Route Number			
	1 and Health tem 27		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of		Date		aryıaı n - City or To	nd 21224
<u>0</u>	Pages nent of int: If it		1 🔀 Burial 2 □ Cremation 3 □ 3 4 □ Donation 5 □ Other (Specification)	Removal from State	emetery, cře klawr	natory or other plac	3/7	7/2005	Balti		
Baltimore, Maryland 21215-0036	permit. Pages 1 am Department of Heali Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licer		2:	2. Name and Addre	ss of Facility	Joseph N	V. Zar	nino	Jr. FH
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Вох	death certific e attending p od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Testonio processo			23d. I	Date of delive	ery
	ie death the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnant at time of d		Ectopic pregnancy Other (specify)			'	Month	Day Year
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Records	e la has	ompleted						autop perfo	rmed?	prior to cor death?	opsy findings available impletion of cause of
Vital	ician: Th certificate rector, pag	e C	25. Was case referred to medical				26 Place of I	1 ☐ Yes Death Check online	2 1 No	1 🗆 Yes	2 □ No
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Division of	or Attendate death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	eet, factory, office		28f. Location (S City or Tov	Street and Nui vn, State)	nber or Rura	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Exar	ysicien: To the best of my kno niner: On the basis of examina	wledge, deat	h occurred at the tin	ne, date and pla pinion, death or	ace, and due to the	cause(s) and	manner as st	tated.
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	170)		Name and indress of person who	completed cluse of death (Item	0 (Type,	Print) Hud	1500	ST.	1	1/20	14
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Physicia		1. Decedent's Name (First, Middle, L	ast)				2. Date of Deat Month	th Day Year	3. Time of Death
/Medica	ıl -	Marsha		I	Bernstein		March 1		4:45 A
Examine	r	4a. Facility Name (If not institution, ga			4b. City, Town, o	r Location of Death		4c. County of Deat	h
	Щ	Sycamore Assist 5. Social Security Number 6.		//www.lasthinth	Derwoo day) If Under 1 Year	d If Under 24 Hrs.	0. D (Dist.	Montgome	
Funeral Director		102-32-3539 Usual Residence of Decedent	1 M 2 XF	92 Yı	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 1	Year) 9. Birt Co	hplace (State or Foreignatry) WYOrk
Mow I	_	10a. State 10b. County		10c. City, Town	or Location		-		10d. Inside City Limit
Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "naturel", or Items 23a or 28e-1 show eny injury or other treumatic svent, the Medical Everthactive trials be multipled at once.	있 누	Maryland Montgom 10e. Street and Number	ery	Derwood	10f. Zip Code		1	0g. Citizen of What Co	1 ☐ Yes 2 🕅 N untry?
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0 pe	m	Max Cooperman	•/			Celia Ro		walden Sumame)	
mark	2	19a. Informant's Name/Relationship	(Type Print)	19h A	Mailing Address (Street			City or Town State	in Code)
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tem		20a. Method of Disposition			Disposition (Name of crematory or other place			20c. Location - City or	Town, State
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edical miner		disease or condition resulting in death)		a consequence of	thic brea	JI CANO	60		oyrs
nslt .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	a consequence of):				
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phys			d						
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ed by the detached	F.	Part II. Other significant conditions	contributing to death bu	it not resulting in t	he underlying cause giv	en in Part I	23e Did tok	pacco use contribute to	the cause of death?
beg .	5				no andonying oddoo gir	or in raiti.		es 2 XNo 3 ☐ Pro	
peen s	ete						24a. Was a	24h Wara au	topsy findings availab
ge 2	Completed						autops	v prior to d	completion of cause of
ector, pag		25. Was case referred to medical	1				perform		2 No
recto	o Be	examiner?	Hospital:	nt 2 ER/Outp	nations 3 DOA Oth	26. Place of Death er:			
三三		27. Manner of Death	28a. Date of Injur (Month, Day		ne of 28c. Injur	4 Nursing Hon		nce 6 Other (Spec	eify)
: After funer	I O	1X Natural 5 ☐ Pending 2 ☐ Accident investigati		Year) Inji		k? Yes 2 □No			
To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not determine	28e. Place of Inju building, etc	iry - At home, fam :. (Specify)	n, street, factory, office	2	28f. Location (St. City or Town	reet and Number or Ru i, State)	ral Route Number,
To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exi	hysician: To the best of the miner: On the basis of and manner sta	examination and/	death occurred at the tir or investigation, in my o	ne, date and place, a pinion, death occurre	and due to the ca	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To th	Me	29b. Signature and title of certifier	. 0		29c. Licens	e number	25	9d. Date signed (Month	, Day, Year)
		1 Clabon	My Kar 1	NP	DOC	51889	and the second	3/1/05	5
5	-	30. Name and address of person who	completed cause of de		ype, Print)	Shell (m. 1.	Rockulle	- 140

UNK 05-01425 05-01425 d1

Physi	rian	Decedent's Name (First, Middle, Caro1	,	Bank				2. Date of Dea	ath 2-24-2	005 Year	12:55 P
/Med	lical			Dalik	100	0° T		Februa	11y 22,	2005	8:30 A
Exam	iner	4a. Facility Name (If not institution, 15033 Hicksvill	•		_	_	or Location of Deat	h	4c. County		
Funera	1		S. Sex 7. Age	e (In yrs. lasi	t birthday) If	lear Sp	If Under 24 Hrs	8. Date of Birt	_ Washi	9. Birthola	ace (State or Fore
Directo		013-40-2431	1□ M 2□XF	55	Yrs.	onths Days	Hours Min.	8. Date of Birt (Month, Da May 23,	1949	New	York
and w		Usual Residence of Decedent 10a, State 10b, County		10c. City. T	own or Locati	on				10	d. Inside City Lin
Maryland f show	JO.	MD Washi	ngton		Sprin					"	1 ☐ Yes 2 🔯
ith the Ma or 28a-f	irec	10e. Street and Number		1		Of. Zip Code			10g. Citizen of V	Vhat Count	ry?
£5 w 23a	Funeral Director	15033 Hicksvill	e Road			21722			USA		
13-UU30 172 hours after dea "natural", or Items	nnei	11. Marital Status	12. Was Decedent I Armed Forces? d 1 \(\text{Yes} \) 2 \(\text{Yes} \)	Ever in U.S.	13. Was	Decedent of H s, specify Cuba	lispanic Origin? (S an, Mexica <i>n</i> , Puer	Specify Yes or No- to Rican, etc.)	14. Raci Blac	e - America k, White, e	
5-0036 72 hours after natural, or ite	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☑ 1141 If Yes, Give Year or Dates:	No	10	Yes 2. XNo	Specify:		Specify	. Whi	te
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ed wi	Son		5+		Clini	cal The	erapist		Mental		n Org.
and lbe fill htal H ed oth	Be	17. Father's Name (First, Middle, La Ralph Burnham	ast)					me (First, Middle,		(8)	
Maryland 21215 d 2 should be filed within 7/ th and Mental Hygiene. 27 is marked other than "n traumatic event, Ire Mad	은	19a, Informant's Name/Relationshi	n (Type, Print)		19b Mailing A	ridrass (Street	and Number or Ri	Lapalm		State Zin (Code
Baltimore, Ma permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau		Carl Bank - Bro					ille Pike				-
altimore, mit. Pages 1 ar partment of Hea portant: if item y injury or othe		20a. Method of Disposition		20b. Plac		n (Name of ary or other place		Date	20c. Location -		
Page Page ment c		1 ፟ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe	B ∐Removal from State ecify)			Cemete		-05	Laure1t	on, N	ew York
mit.		21. Signature / Funeral Service Li	cersee	201		me and Addre				-	
n ೩೭೯೪	S	Mel	us oold	IX)	X 175	N. Lor	ng Beach	Road Roc	kville	Centr	e. NY
		23a. Part 1. Enter the disease, or c shock, or heart failure. List of	omplications that caused nly one cause on each lin	I the death. I	Do not enter th	e mode of dyin	ng, such as cardia	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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entific ling pl	Medi	IF FEMALE:	00- 4								
BOX 60 eath certific attending p	lan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3 Ect	opic pregnancy ner (specify)	<i>y</i>		23d. Date Mor	e of delivery oth E	/ Day Year
that the de ed by the detached	hysici	1.□,Yes 2□No 9□Unknown	9 Unknown	time or deati	11 3 U	ier (specily)					
The Colds, F.O. BOX 601 The law requires that the death certificate ale has been signed by the attending phys page 2 should be detached for use as the	by Pr	Part II. Other significant condition	s contributing to death bu	ut not resultir	ng in the under	tying cause giv	ren in Part I.	23e. Did to	bacco use contr	ibute to the	cause of death?
v requires been sign	ठ							1 🗆 Y	es 2□No	3 ☐ Probai	bly 4 Unkno
aw requise been 2 should	omplete							24a. Was	an 24b. V	Vere autops	sy findings availa
The law ate has page 2 s								autop perfor 1 🗷 Yes	med? d	eath?	pletion of cause
lta sitifica ctor, r	Be C	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only or		7/3	
Of VITAL He Physician: The la r this certificate had	ျ	1X Yes 2 □ No	Hospital: 1 Inpatie		/Outpatient :		4 Nursing	lome 5 Resid	ence 6 XOthe	er (Specify)	scene
on of ding Phy h. After thi funeral of	ation:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injur (Month, Day	ry Year) 28		28c. Injun Wor			ow injury occurre		
ISIO Ntendi death. ctor: A y the fu	cat	2 Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be Diego of Inju	unu. At harma			Yes 2 No	Victim (of a bui	1ding	fire
DIVISION OF VITAL HECONGS, i or Attending Physician: The law requires tafter death. Director: After this certificate has been signe in by the funeral director, page 2 should be	ertifica	4 Homicide determin	28e. Place of Inju- building, etc Residence	c. (Specify)	e, ram, street,	factory, office		28f. Location (S City or Tow	n, State 1503	3 Hic	ksville
spita ours nerai	O	29a. Certifier 1 ☐ Certifying	Physician: To the best of		dge, death oc	curred at the tin	ne, date and place	Clear S			ned.
To the Hos within 24 h To the Fur completely	edical	(Check only 2X Medical E. one)	caminer: On the basis of and manner sta	examination	and/or invest	gation, in my o	pinion, death occu	rred at the time, o	late and place, a	nd due to t	he cause(s)
To the I within 2 To the I complet	×	29b. Signature and title of certifier	1 0		2	29c. Licens		1	29d. Date signed		*
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12/		30. Name and address of person w	no completed cause of de				enn Stree) I	CINUC	WY	78,7 <i>00</i> nd 2120

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Robert Boynton 01:40A M 03 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRECCII- Veterans Health Core Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 2□ F 267-12-7541 Yrs. Director 80 JUNE 14 1924 FLORIDA Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28e-f shov odical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2617 E. Oliver Street Baltimore E, xy 21213 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Xes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4or 5+) unknown MARINTIME SEAMAN SHIPPING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be marked 2 ANGUS BOYNTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: if item 27 is any injury or othar trau <u>900.9</u>. 2617 E. Oliver Street., Balticore, M.L. ce of Disposition (Name of Date 20c. Location City or Roberta Boynton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) GARRISON FOREST 03-11-05 OWINGS MILLS, MARYLAND 21. Signal of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Mara 1206 W NORTH AVENUE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Carcinomo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): nding physician a use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has to autopsy performed? certificate 23+10 1 Yes 2 100 the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Thursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 1 16 this 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: / in 24 hour.
I the Funeral Dirac. 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) M. D. 091804 03/03/2005 houses 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. MROWIEC 3900 Loch Blod. Baltimore Raven 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Physici	ian	Decedent's Name (First, Middle, Last) M	Teresa Michel	Lle Bogst	tad to of		2. Date of De Month	Day		
/Media		4a. Facility Name (If not institution, give stre			4b. City, Town, o	r Location of De	Februar		County of Dea	
Examir	ner	The Johns Horkins			Balhir		City		. County or Bot	411
uneral		5. Social Security Number 6. Sex		s. last birthday		If Under 24 H Hours Mi	n. (Month, Da	ay, Year)	9. Bi	irthplace (State or Fore
irector		Usual Residence of Decedent	A One				Oct.1,	, 200.	3 80	ston, MA
how		10a. State 10b. County		City, Town or L	_ocation					10d. Inside City Lim
Ba-f s	Director	MA Middles	ex	Cambri				-		1 Yes 2
ben ben	Ö	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What C	Country?
ne 23	Funeral	22 Hadley Street 11. Marital Status 12.	Was Decedent Ever in	U.S. 13	. Was Decedent of H	lispanic Origin?	(Specify Yes or No)-	US 14. Race - Am	
er, or teme 23s or 26s-1 snow Examiner must be nutilied at	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cubin 1 Yes 2 No	Specify:	erto Rican, etc.)		Black, Wh	
solical Ext	Completed	15. Decedent's Educat (Specify only highest grade c	ompleted)	16a. Dec (Giv life.	edent's Usual Occup le kind of work done DO NOT use retired	eation during most of w	vorking	16b. K	ind of Busines	s/Industry
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vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maiden		•
atic a	70 6	William J. Bogsta	d			Lenore	2		Cowe	n
Te um		19a. Informant's Name/Relationship (Type,			ling Address (Street				or Town, State,	Zip Code)
other t		Mr. William J. Bogs 20a. Method of Disposition			Hadley St	reet, Ca	mbridge,		02140 ocation - City o	Town Chata
- b		1 Tagrial 2 ☐ Cremation 3 ☐ Rem	noval from State	cemetery, cri	ematory or other pla					
injury e		' 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	241		ge Cemete: 22. Name and Addre	-	25,200		Cambrid	ge, MA alth Avenu
any i			/ / /					1 1.0	illillionwe:	airn awenn
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			For State Registrar	State of Maryland / D	Department of Health and I Certificate of Death	Mental Hygie	•	07391
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Bernard Jerome	Curtis		2. Date of Death Month	Day Year 5, 2005	3. Time of Death
	Examin Funeral		4a. Facility Name (If not institution, give s Caton Manor Nur 5. Social Security Number 6. Sex	rsing Home 7. Age (In yrs. last birt		8 Date of Birth	4c. County of Death N/A	place (State or Foreign
	Director		217-18-5016 122 Usual Residence of Decedent 10a. State 10b. County	IM 2□ F 81	frs. Months Days Hours Min.	July 23	, 1923 M	aryland 10d. Inside City Limits
	the Maryl	rector	Maryland N/A	Ва	ltimore 10f. Zip Code	100	. Citizen of What Cou	Y Yes 2 No
	eeth with	Funeral Director	3021 W. Lanvale	2 Street 12. Was Decedent Ever in U.S.	21216	U	SA 14. Race - Amer	
900	within 72 hours after deeth with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow the Medical Examinat must be conflied at	ð	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? ¥☐Yes 2☐No If Yes, Give WW 2 Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert □ Yes 2 No Specify:	o Rican, etc.)	Black, White	, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Health and Mental Hygjene. Importants if item 27 is marked other than "natural", or iteme 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examination must be confilled at ADES.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 11th grade	college (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Gineer	king	b. Kind of Business/lo	
Maryland 2	should be filed vind Mental Hygie marked other tumatic event, El	To Be C	17. Father's Name (First, Middle, Last) Robert Curtis		18. Mother's Nar Alverta	ne (First, Middle, Ma a Willian	ms	
	s 1 and 2 sho of Health and Item 27 is my other traumi		19a. Informant's Name/Relationship (Ty, Louise Curtis/ W	life 30:	Mailing Address (Street and Number or Ru 21 W. Lanvale St			
Baltimore,	permit. Pages 1 a Department of He Important: If item any injury or oth once.		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	Green	mount Cemetery	2/05 Ba	c. Location - City or T	, Maryland
Bal	permit. Departr Imports any inj		21. Signature of Funeral Service License	His	22. Name and Address of Facility Cl 5240 Reisterston	n Rd Ba	ltimore,	meral Home Md 21215
	Physician /Medical Examiner		21a. Part Enter the disease, or compliment, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not not cause on each line. aue to (or as a consequence.	oot enter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
8760, <	ate be executed hysician and the burial-transit	ilcal Examiner	Sequentially list conditions, and active the sequential of the seq	Due to lor as a consequence of	n): 			4
.O. Box 68	ath certific titending p or use as	Physician/Med	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	I3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	very Day Year
ecords, P.	w requires that the de been signed by the a should be deteched f	by	Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to	
α		Completed				24a. Was an autopsy performe 1 ☐ Yes 2 \(\bar{\Delta} \)	prior to co	opsy findings available ompletion of cause of
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 100	fospital: 1 Inpatient 2 ER/Out	Other	th (Check only one)	e 6 Other (Speci	(fv)
Division of	ding h. After fune		27. Manne Death 1 Vatural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. T	ime of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how		
DIVIS		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, lar building, etc. (Specify)		City or Town, S		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	, death occurred at the time, date and place d/or investigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as a and place, and due t	stated. to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	Ceolo	DH76HH	29d.	Date signed (Month,	Day, Year)
	5		U21N1 00 10	ompleted cause of death (Item 23a) (W Stleet Su	Type. Print) 2 Bolling	op MD	2/20/	1
	Sta Registi		31. Date filed (Month, Pay, Year)	32 degistrar's Signature	Siele			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 5 0 7 3 9 2

Certificate of Death

Reg. No.

			1 - State Registrar		Certifica	ate of Death	Reg. N	lo.	01002
	Bhusia	ion	Decedent's Name (First, Middle, Last)	()			2. Date of Death	ay Year	3. Time of Death
	Physic /Med		HENRY F.	CONSTAN	TINE		3 2	05	5:55 A.M
	Exami	ner	4a. Facility Name (If not institution, give s	0	4b. C	ity, Town, or Location of Death		c. County of Death	
			5. Social Security Number 6. Sex	onter 7. Age (In yrs.	last hirthday) If I In	TOCUSON der 1 Year If Under 24 Hrs.		BALTIM	
	Funeral Director		JOS-OS-J397 11	M 2 F 7. AGB (III y/s	9 Yrs. Month		8. Date of Birth (Month, Day, Yea	9. Birthe	place (State or Foreign ntry) YLALL
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
	Mary I-1 sh	ţō	MD RATIO	OPE	Tow	(102			1 ☐ Yes 2 No
Th	ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examination in the Inditited at	Funeral Director	10e. Street and Number	A 1 :		Zip Code	10g. C	Citizen of What Cour	ntry?
>	s 23a	rai	615 Chestnut	Ave. Ap	1326	21204		USH	
1	ter de	-ra	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U Armed Forces? 1 DYYes 2 No	13. Was De	specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	an fndian, etc.
3	21215-0036 d within 72 hours after giene. er then "natural; or Ite	l by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	s 201 No Specify:		Specify: 11)	ite.
12	5-0	etec	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's U (Give kind of	Isual Occupation work done during most of work T use retired)	sing 16b.	Kind of Business/In	dustry
15	nd 2121 e filed within al Hygiene. I other than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		ntant	0	SV Rai	lound
2	illed Hygin other	Be C	17. Father's Name (First, Middle, Last)		I I CCCO	7,7	e (First, Middle, Maide	on Sumame)	RUCIU
C	faryland 2 should be file and Mental Hy Is marked oth sumatic event	To B	Henry N. Co	NStan tin	0	Emma	_ C. Ge	ORGE	
	Mary d 2 shoul th and M 7 Is mar traumati		19a. Informant's me/Relationship (Ty)	pe, Print)	19b. Mailing Addre	ess (Street and Number or Rui	al Route Number, City	or Toym, State, Zip	Code)
2	or Health of Health item 27		Janu Constan	ALAL Jans	(((6) C(L) Place of Disposition (f	Strutter, 4		TOWSON	
EK .	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 R	emoval from State	cemetery, crematory of	or other place)	2 1 1 2	Location - City or To	Mar NO
YE	Baltimo permit. Pag Department Important: I any injury o		' 4 □ Donation S □ Other (Specify) 21. Signature of Funeral Service License		usture ral	and Add ss of Facility		torest	
7	Demi		Kini be as ()	3 STATE	C.	- OH	LTIMORE JEL SCUHT		
2	TO STATE OF		23a. Part1. Enter the disease, o compli- shock, or heart failure. List only on	cations that caused the de-		node of dying, such as cardia	or respiratory arrest,	RI CKI)	Approximate
0	Physician		Immediate Cause (Final disease or condition		+ 1				Interval Between Onset and Death
7	/Medical		resulting in death)	Due to (or as a consec					gene
exo.	Examiner		Sequentially list conditions, b		200 1 2 2 2 1 W				
01	led list	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	(Ienna-of):				
M	execui n and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	uence of):				
4	X 68760, Ccertificate be executed uding physician and use as the burial-transit			I					
10	X 68 certifica ding ph	/Medical	IF FEMALE:						
N			23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta	il death 3 □Ectopic	pregnancy		23d. Date of delive Month	ery Day Year
A 3	cords, P.O. Bo wrequires that the death of been signed by the atten should be detached for u	by Physician	1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of o 9☐Unknown	leath 5 🗌 Other	(specify)		WOITH	Day
	that the hold by deta	y Ph	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
+	Vital Records, ician: The law requires to certificate has been signe rector, page 2 should be or	q pa	Depression	1			1 🗆 Yes	2 No 3 □ Prob	pably 4 Unknown
9	as a co	Completed					24a. Was an	24b. Were auto	psy findings available mpletion of cause of
1	Vital Recition The law certificate has rector, page 2	Com					autopsy performed? 1 Yes 2 X N	death?	
S	/ita	Be (25. Was case referred to medical examiner?				h Check only one)		
-	Of Physi	10	1 192 5 KINO		-	DOA Other: 4 Nursing Ho	me 5 Residence	6 Other (Specify	n Hospia
12	VISION Of VITAI RECONDS, P.O. BK Attending Physician: The law requires that the death reach. sctor: After this certificate has been signed by the atter by the funeral director, page 2 should be detached for u	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred	*
3	DIVISION or Attending after death. Director: Afte	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Specil	ome, larm, street, fact	tory, office	28f. Location (Street a City or Town, Sta	and Number or Rura	I Route Number,
	Utal or urs after ral Dir	Cer	T I TISKING S	Duilding, etc. (Specia	y)		City of Town, Sta	:0)	
	Division of Vital Re To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	Medical	29a. Certifier Check only one) Check only 2 Medicel Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurrention and/or investigati	ed at the time, date and place, ion, in my opinion, death occur	and due to the cause(red at the time, date ar	s) and manner as st nd place, and due to	ated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	1 - 4	- 2	29c. License number	29d. D	ate signed (Month, I	Day, Year)
	1	J	1 M Chille	, Kely ac	ug !	1)25205	m	Hich 2	2005
	15		30. Name and address of person who co	1 1		1) 25205 N. Charles S	. 0 0.	5	
			W. H-K. Ley	G45mc	6701	M. Charles J	t. BCCLYt	md 21	cox
	St	ate	31. Date filed (Month Pay, Very) 200	Registrar's Sign	Pure Asset	7			

			For State Registrar		Maryland / De <i>C</i>	partment o ertificate		F	Reg. No.	07393	
ı	Physici		1. Decedent's Name (First, Middle, Last) Bur lcu						Day Yea		
	/Medic Examin		4a. Facility Name (If not institution,	give street and numbe	ər)	4b. City, To	vn, or Location of Dea	March	4c. County of De	2	
	LAGITIT	CI	The Johns Hopk	ins Hospi	ital	Balt	impre C	ity	Baltimor	~e	
	Funeral			5. Sex 7. /	Age (In yrs. last birthda	y) If Under 1 Y		8. Date of Birt		lirthplace (State or Foreign Country)	
	Director		235-32-7845	1∭M 2□F	74 Yrs.	Months D	ays Hours Min	(Month, Da) Apr. 29	, 1930 Ohi	Lo	
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than *natural', or Itams 23a or 28a-1 show unafte event, the Medical Examinar must be notified at		Usual Residence of Decedent 10a. State 10b. County		10- 05- 7						
		2	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits 1 X Yes 2 □ No	
		Director	Virginia Culpepe	<u>er</u>	Culpeper	1:21 =1 =					
	with t	Ö	10e. Street and Number			10f. Zip Co			10g. Citizen of What (
	sath	erai	2017 Golf Drive 11. Marital Status	12. Was Deceder	at Ever in 11 S	227			United Sta	nerican Indian.	
10	ter d	Funerai	1 Never Married 2 Marrie	Armed Force	is?	If Yes, specify	of Hispanic Origin? (Cuban, Mexican, Pue	rto Rican, etc.)	Black, Wi		
38	urs af	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2 🔀	No Specify:		Specify:	/hite	
Ą	2 hou	ted	15. Oecedent's		16a. De	cedent's Usual C	ccupation	4.:	16b. Kind of Busines		
215	within 7 ene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	life	o. DO NOT use r	one during most of wo etired)	orking			
21	filed wii Hygien sther th	Con		4		eting Re	presentati		Ryan Homes	3	
nd	be fill tal Hy od oth sveni	Be	17. Father's Name (First, Middle, La	ist)			18. Mother's Na	me (First, Middle,	Maiden Sumame)		
yla	0 8 8	으	Harry G. Rust					e Clowto			
Var			19a. Informant's Name/Relationship				reet and Number or R Drive Culp		r, City or Town, State	, Zip Code)	
Baltimore, Maryland 21215-0036	is 1 and 2 of Health item 27 l other tra		Candace K. Crowe	2/Daughter	20b. Place of Dis			Date Date	20c. Location - City of	or Town State	
5	Pages nent of l nnt: If its iry or o		1 ☐ Burial 2 🛣 Cremation 3		te cemetery, o	rematory or othe	r place)				
Ŧ.	7 E E E E	l í	* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		Johnson 0321				Locust Gro ish Funera		
Ba	permi Depa Impo any it		Mancel 1	Box	10/1/1				ulpeper, V		
	death certificate be executed He attending physician and a for use as the burial-transit and the transit and the transit and the transit and the transit and the transit and the transit and the transit and tran		23a. Part1. Enter the disease, or conshock, or heart failure. Hist or	omplications that caus	we cu					Approximate	
			Immediate Cause (Final		kemia					Interval Between Onset and Death 23 months	
1			disease or condition resulting in death)	a	as a consequence of):					Zy mortific	
			Sequentially list conditions	b							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dause (United to a rinjury)		as a consequence of):						
		Examiner	that initiated events resulting in death) Last	c.	as a consequence of):						
8760,	be ex ician buria	aiE	,	Due 10 (0)	as a consequence on.						
687	ficate physics the	edicai		d.							
Вох	eath certific atlending p	N/M	IF FEMALE: 23b. Was decedent pregnant	ne of pregnancy				23d. Date of delivery			
	death e atle	hysician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9☐ Unknown						Month Day Year		
P.0	requires that the de neen signed by the a hould be detached	hys	9 🔲 Unknown	-							
Ś		by P	Part II. Other significant condition	s contributing to death	n but not resulting in the	underlying caus	e given in Part I.	23e. Did to		to the cause of death?	
ord	w requir been si should	ted						1 🗆 Y	es 2 No 3 I	Probably 4 Unknown	
Vital Record	law as b 2 si	ompieted						24a. Was a autop	sy prior to	autopsy findings available completion of cause of	
<u>=</u>	Th ate pag	Con						perfor 1 ☐ Yes	med? death? 2XNo 1 ☐ Ye		
Vita	ician: certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital				ath (Check only or	ne)		
ot	ding Phys h. After this funeral dir	<u>۲</u>	1 Yes 22 No Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
		tion	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 4 28d. Describe how injury occurred 4 28d. Describe how injury occurred 4 28d. Describe how injury occurred 4 28d. Describe how injury occurred 4 28d. Describe how injury occurred 4 28d. Describe how injury occurred 4 28d. Describe how injury occurred 4 28d. Describe how injury occurred 4 28d. Describe how injury occurred 5 28d. Describe how injury occurred 4 28d. Describe how injury occurred 5 28d. Describe how injury occurred								
Division	l or Attending after death. Director: Aftel in by the fune	ertification;	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of I	Injury - At home, farm,				treet and Number or I	Rural Route Number,	
<u>S</u>	el or A	Certi	4 Homicide	building,	etc. (Specify)			City or Tow	n, State)		
	Hospitel or 24 hours after Funeral Direstely filled in E		29a. Certifier (Check only 2 Medical Ex	Physician: To the be	st of my knowledge, de	eath occurred at t	ne time, date and place	e, and due to the c	ause(s) and manner	as stated.	
	the pole	ledical	one)	and manner	s of examination and/or stated.						
	To To Con	Σ	29b. Signature and title of certifier	٨		29c. Li	cense number		29d. Date signed (Moi		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						D				March 1, 2005	
	3		30. Name and address of person with Rosalyn Juergens				Howkins C	KB-186 F	Baltimore	MD 21231	
	Sta	te	31. Date filed (Month, Day Vear)	2. Regis	strar's Signature	dep			-41 III. IO. C	//	
	Registr		MAK U / ZI	GUK	UN AS	od)					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** MARCH CHARLES M. DEMPSEY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Months Days Hours Yrs. Director NOV 6, 118.10.0566 81 NY Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic avent, the Medical Examinar must be notified at Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4215 BAYONNE AVE USA 21206 Funera 12. Was Decedent Ever in U.S. Armed Forces? YY Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or Itel XX Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: by 3 Widowed 4 Divorced Year or Dates: XX WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 OFFICE ADMINISTRATOR GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY O'KEEFE MICHAEL DEMPSEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8058 SENECA TURNPIKE CLINTON, NY 13323 CARLTON CONVERSE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ertment of ortant: If it Warial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) PETER'S CEM 3.8.2005 ROME, NY Departm Importa any nju onca. 21. Signature of Funeral Service Licent FINK FUNERAL HOME, P.A. GREGORY FINK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a POWLT RESPERATORY DISTRESS disease or condition resulting in death) /Medical **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Phyalcian: 25. Was case referred to medical 26. Place of Death (Check only one) - examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funaral I 29a. Certifier 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of c 29c. License number AT2438946 03-02-2003 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) FAHD AMJAN 201 EAST UNIVERSITY PARKWAY BALTIMORE MD 21218-2895 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State MAR 0 7 2005 Registrar

			State of Maryland / Department	partment of Health and Mental Fertificate of Death	Hygiene Reg. No. 2005 07396					
			Decedent's Name (First, Middle, Last)	2. Date of	Death 3. Time of Death					
	Physicia /Medic		Joseph Raymo:	nd Derencz Marc	Day Year 6:30 A A					
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
п			135 South Robinson Street	Baltimore City	N/A					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month,	Birth 9. Birthplace (State or Foreign Country)					
	Director set at		215-40-9678 60		11,1945 Maryland					
		1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits					
		ō			1 ⊠Yes 2 □ No					
	the 28a-	Director	Maryland N/A	Baltimore City 10f. Zip Code	10g. Citizen of What Country?					
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or ttems 23a or 28a-f show aumatic event, the Medical Examinar must be notified at		135 South Robinson Street	21224	United States					
		Funerai		3. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.						
٥			1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☑ No Specify:						
215-0036	ral, c	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	THE TES ZONING SPECIFY.	Specify: White					
ה	72 h 'natu	Completed	(Specify only highest grade completed) (Gi	pedent's Usual Occupation we kind of work done during most of working	16b. Kind of Business/Industry					
2	ne. han	d H	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)						
N	iled v Hygie her t	ပိ	12 Years Lis	aborer 18. Mother's Name (First, Mid	Construction					
ang	9 m 2 ×	Be								
$\frac{2}{5}$	hould d Me mark matic	2	Joseph Derencz 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Ma	Anna Kroli iling Address (Street and Number or Rural Route Nu						
Maryland 21	d 2 s th an t7 is trau		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	5 South Robinson Street						
οĴ	Pages 1 and 2 should bent of Health and Mentint: If item 27 is marked into or other tranmatice		20a Method of Disposition 20b. Place of Dis	position (Name of Date	20c. Location - City or Town, State					
0			1 □ Burial 2 ☑ Cremation 3 □ Hemoval from State	imatory or other place) Service Corp. 3/2/200	5 Towson, Maryland					
Ī	permit. Page Department Important: Il any injury o	S	21. Senture of Funeral Service Licensee	22. Name and Address of Facility	*					
ñ	Der Imp		o (aull	Duda-Ruck Funeral Home 7922 Wise Ave. Dundall	of Dundalk, Inc. c, Maryland 21222					
	1111		23a Part. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.							
	Physician		Immediate Course /Final	tucin	Onset and Death					
	/Medical		resulting in death) Due to (or as a consequence of):							
ш	Examiner		Sequentially list conditions.							
ia	sit 8d	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
FF	and I-tran	Examin	that initiated events resulting in death) Last C							
8760,	icate be executed physician and s the burial-transii	aiE	255 16 (6) 45 45 255 155 455 157							
289	The faw requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	edicai	d							
Rox	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	B⊟Ectopic pregnancy	23d. Date of delivery					
ň	death e atte d for	icia	in the past 12 months? 1 Vac. 2 No. 4 Pregnant at time of death	Month Day Year						
J.	t the by the lache	hys	9 Unknown							
	res that the de signed by the a be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in the	Did tobacco use contribute to the cause of death?						
ğ	w require been si should b									
ပ္ပ	e law r has be je 2 sh	ple	Coronay Aring D	24a. V	utopsy prior to completion of cause of					
Vital Records,		Completed	REFLUX Escophagital	performed? death? Yes 220 No 1 ☐ Yes 2 ☐ No						
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check or	nly one)					
1	hyai this o	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		Residence 6 Other (Specify)					
Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	lon:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		be how injury occurred					
<u>S</u>		icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		on (Street and Number or Rural Route Number,					
<u>></u>		Certification:	4 Homicide determined building, etc. (Specify)		Town, State)					
	spita hours neral / fillec	Medical Co	29a. Certifier Teacher: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	ne Ho n 24 h ne Fu sletelly		(Check only one) 2 Medicel Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the tir	me, date and place, and due to the cause(s)					
	To the within 2 To the complet		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
			*	3-1.00						
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
	V		SINON SCHIM WESTON HUNDER ST	18 mm us us	14					
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 7 2005 31 Registrar's Signature	الكام						
	negisti	aı	tin tr	1						

		4	1 - For State Registrar	State of Maryland	-	rtment of Ho		F	Reg. No.	05 07397
ű.	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Muriel Lorrai	ne Fore				2. Date of Dea Month Februa	Day	3. Time of Death Year 2005 4:20 PM
	Examin	-611	4a. Fecility Name (If not institution, give so Holy Cross Nursin			4b. City, Town, or Burton		1		y of Death gomery
**	Funeral Director	10.00	229-12-8267	M 2 F X 82	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Dec 18	v, Year)	9. Birthplace (State or Foreign Country) Virginia
	show	or	Usual Residence of Decedent 10a. State 10b. County		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a-f	Director	MD Montgomer 10e. Street and Number		rtonsv	10f. Zip Code			_	What Country?
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic avent, its Madical Exam as it in the Madical Exam as it in the Madical Exam as it is in the Madic	Funerai	1 Never Married 2 Married	Road 2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give X		Vas Decedent of His f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert Specify:		USA 14. Ra Bla Specii	ce - American Indian, ack, White, etc.
21215-0036	iin 72 hours n "naturei", Aedical Exe	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of war	king		White Business/Industry
nd 212	be filed with tal Hygiene d other the event, ILE	Be	17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Spe	ech Write	18. Mother's Nar	ne (First, Middle,		al Government me)
Maryland	should to and Meni merked umatic a	은	James W. Fore 19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	g Address (Street a	Minnie nd Numberor Au		r, City or Town	n, State, Zip Code)
2	Health Health tem 27 other tr		Betty Divine - Ni 20a. Method of Disposition 1 Disposition 3 Re	20b. Pla emoval from State	ce of Dispos netery, crem	Fenwick I sition (Name of natory or other place)	Date	-	24592 - City or Town, State
	permit. Pages Department of Important: If is any injury or o		4 □ Donation 5 □ Other (Specify) 21. Signatur: 1 Funeral Service License		22 W	1 Cemeter Name and Address Trenn-Yeat 03 N. Mai	of Facility	5-05 ral Home	+	lle, VA
	Physician /Medical Examiner	ć	23a. art1. Enter the disease of complic shock, of heart failure. List only on mmediate C use (Final disease or condition resulting in death)		Do not ente	er the mode of dying	, such as cardiad	or respiratory and	rest,	Approximate Interval Between Onset and Death
60,	ate be executed hysician and the burial-transit	cal Examiner	Sequentially list conditions, any loading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a conseque						
.O. Box 68	death certific e attending p d for use as f	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dead 9 ☐ Unknown	leath 3	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year
rds, P.	w requires that s been signed by should be deta		Part II. Other significant conditions conf	tributing to death but not result	ting in the ur	nderlying cause give	n in Part I.		bacco use con	atribute to the cause of death?
	The la ate has page 2	Completed						24a. Was a autop perfor 1 ☐ Yes	med?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
	lysicien: Th iis certificate director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 E	R/Outpatien	t 3□ DOA Othe		th <i>(Check only or</i> ome 5 ☐ Resid	11-2-2	her (Specify)
Division of	ding Ph After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury Work	at	28d. Describe h		
		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Tow	n, State)	ber or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	edical	29a. Certifier 1	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occu	, and due to the or rred at the time, o	ause(s) and made,	anner as stated, and due to the cause(s)
	To the within 2. To the I complet	Σ	29b. Signature and title of certifier Samue Che	in fitts, m	. 0	29c. License				ed (Month, Day, Year)
	1		30. Name and address of person who cor	mpleted cause of death (Item :	23a) (Type, I	7616 A	lassena	Rd. Bet	hesda	y 28, 2005 , MD 20817
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 7 2005	32. Registrar's Signatu	for the	P.				<u> </u>

			1 - For State Registrar	State of Maryland		nent of H			giene	2005	1 07300
	Physici /Medio		1. Decedent's Name (First, Middle, Last	n FRY				2. Date of Dea Month	ath Da	y Year	3. Time of Death
	Examir	ier	4a. Facility Name (If not institution, give 2508 12 H21 5. Social Security Number 6. Se	7. Age (In yrs. last	(ARKV Inder 1 Year	Location of Deat	8. Date of Birt	h v, Year)	9. Bir	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent 10a. State 10b. County	- 50	Town or Location	1		HU6-21	195	يقرا لما	10d. Inside City Limits
	r 28a-f sh	Director	MARAGO BALTING 10e. Street and Number	DE A	10 KV. 11	f. Zip Code			10g. Cit	izen of What C	1 ☐ Yes 2 No
036	n 72 hours after death with the Maryland "natural", or frems 23a or 28a-f show saitest Examinat must be notified at	by Funeral D	3508 Michs 11. Marital Status 1 Never Married 250 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year, Older Dates:		Pecedent of Hi specify Cuba es 25 No		Specify Yes or No- to Rican, etc.)		14. Race - Ame Black, Whi	
21215-0036	within ene. than *	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's (Give kind of life. DO No	of work done of OT use retired,	turing most of wo		16b. K	ind of Business	GE SUC
Maryland ;	be filer Ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last)	DATTILO				me (First, Middle,	Maiden	Sumame) 🐍	DK
	1 and 2 sho Health and em 27 Is m thar traum		19a. Informant's Name/Relationship (T) MICHAEL A-FRY 20a. Method of Disposition	20h Plac	ASOS (7)	(Name of	LAR	Date 2	12	cation - City or	900 a18371
Baltimore,	permit. Pages Department of Important: If it any Injury or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Surplus Fun Set e Licens			(2, F)-	is of Facility		OR:	11.H721	MARYLAND 8x1200
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or come shock, or heart failure. List only disease or condition resulting in death)	cations that caused the death. In cause on each line. Due to (or as a consequent)	Do not enter the		g, such as cardia		rest,		Approximate Interval Between Onset and Death
8760,	rate be executed physician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent Due to (or as a consequent d.							
O. Box 6	the death certific y the attending p iched for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 275 No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ector	oic pregnancy or (specify)				23d. Date of de Month	livery Day Year
rds, P	sign d be	by	Part II. Other significant conditions con	tributing to death but not resulting	ng in the underly	ing cause give	on in Part I.		bacco (_	o the cause of death?
of Vital Records,	The law ate has b page 2 sl	Completed						24a. Was a autop: perfor 1 Yes	sy	prior to death?	utopsy findings available completion of cause of 2 \(\subseteq \text{No} \)
ion of Vita	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	The state of the s	Outpatient 3[b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing H	ath (Check only or fome 5 Residence 28d. Describe h	ence		cify)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fa	ctory, office		28f. Location (S City or Town			ural Route Number,
	the Hospi nin 24 hour the Funer npletely fill	Medical	(Check only 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death occu and/or investiga	ation, in my op	inion, death occu	irred at the time, d	late and	place, and due	to the cause(s)
)	North Con	~	29b. Signature and title of certifier	m Hol		29c. License				SRCJ4	
	15		30. Name and address of person who co	mpleted cause of death (Item 23	Ba) (Type, Print)	YEN BI	VO. BE	Winora	0	arrigo	2,2002
	Sta Registr	- 4	31. Date filed (Month, Day, Year) MAR 0 7 2005	2. Registrar's Signature	And I	•			1		

			1 - For State Registrer	State of M	-	epartment of Certificate of		nd Mental Hyg	iene eg. No 2005	07399
	Physici		1. Decedent's Name (First, Middle, Las		CH			2. Date of Deat Month	Day Year	3. Time of Death
	/Medio Examin		4a. Fecility Name (If not institution, give)	Tow	n, or Location of	Death	4c. County of Death	00E
	Funeral Director		5. Social Security Number 6. S 216 · 16 · 23 · 4	9X 7. A	ge (In yrs. last birth 83 Yr	Months Da		Min. (Month, Day,	Year Cou	place (State or Foreign ntry)
	show	or	Usual Residence of Decedent 10a. State 10b. County RACII	NOTE:	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 XNo
	th the N or 28a-f	Director	10e. Street and Number	O	GLE	10f. Zip Cod	*	1	0g. Citizen of What Cou	
	s 23a		11521 HANNIB		(F - 110)	210		0/0	USA	and the state of
936	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural; or items 23s or 28s-1 show other traumatic evant, the Madical Examinal must be nutitied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Tyes 2 If Yes, Give Year or Dates:	7 No	If Yes, specify C	Cuban, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ameri Black, White, Specify: W	
2-0	72 hou	eted	15. Decedent's Ec	lucation	16a. D	ecedent's Usual Oc Give kind of work do	ne during most o	of working	16b. Kind of Business/In	ndustry
21215-0036	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	ife. DO NOT use re	EL.			ME
Maryland	should be fi nd Mental H marked ott umatic evan	To Be	17. Father's Name (First, Middle, Last) WALTER C	CHAR	FFMAN		BL	s Name (First, Middle, M AN CHE	BAR	EHAM
	and 2 sho ealth and n 27 Is mu	,	19a. Informant's Name/Relationship (1 4	62257	DAS CAC		r, City or Town, State, Zip EN ARM (
Baltimore,	00-		20a. Method of Disposition 1 Burial 2 Cremation 3	-,-	20b. Place of D	Disposition (Name of crematory or other			20c. Location - City or To	own, State
Him	t. Pa rtmer rtant		* 4 □ Donation 5 □ Other (Specification 21. Signature) of Funeral Service Licer	()	<u>NE220</u>	011 (100	CENTER!	PEACEFUL AL	Joneks	MD
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	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that causone cause on each t	d the death. Do no	imers	dying, such as ca	rdiac or respiratory arro	est,	Approximate Interval Between Onset and Death
	/Medical Examiner				s a consequence of):				
	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate case. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of					
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S, D	res that the igned by be detac	by Ph	Part II. Other significant conditions of	ontributing to death I	but not resulting in t	he underlying cause	given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
ord	w require been sign	eted						822982==	es 2 □No 3 □ Prot	
Vital Records,	The la ate has page 2	Completed						24a. Was all autops perform	ned? death?	opsy findings available impletion of cause of
Vita	Physician: Th this certificate ral director, paç	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpati	ient 2 ☐ ER/Outp	atient 3 DOA	0.1	f Death (Check only on	e) ence 6 □Other (Specia	(v)
ion of	nding Phy tth. :: After this e funeral c		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ury 28b. Tir	ne of 28c. I	njury at Work? 1 □ Yes 2 □ No	28d. Describe ho	ow injury occurred	,,,
Division	al or Atts s after des il Diractor od in by th	Certification:	3 Suicide 6 Could not be determined	286. Place of in	ijury - At home, farn tc. <i>(Specify)</i>	n, street, factory, offi	ice	28f. Location (St. City or Town	reet and Number or Rura 1, State)	al Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	ledical C			of examination and/				ause(s) and manner as s ate and place, and due t	
	To the Comp	ž	29b. Signature and title of certifier	1 00	2/20		ense number		9d. Date signed (Month,	
,			30. Name and address of person who	completed cause of	death (Item 22a) T		00544		2-28-0	
	4		Cyrus Asac	11/20	E. TIN	ronium	rd #2	og Timon	ium, MD	2183
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 7 200	32. Regist	trar's Signature					

	_		1 - For State Registrar			Marylar	-	artment of <i>rtificate of</i>		and Mei		giene	nne	07400
	Physic /Medi		1. Decedent's Name (First,) Vernon C	Fir	nell					-	Date of Dea Month	ry &	4 200	5 4:40 PM
	Exami	ner	4a. Facility Name (If not insti Stella Ma					4b. City, Town, Baltim		of Death		4c.	County of Dea	ath
	Funeral Director		5. Social Security Number 217-26-9434 Usual Residence of Decede	·	X X M 2□ F		last birthday) 74 Yrs.	If Under 1 Yea Months Days		Min.	Date of Birth (Month, Day or i1	v, Year)	9. Bi	rthplace (State or Foreign Jountry) aryland
	Maryland f ahow	or	10a. State 10b. Co		' A		y, Town or Lo							10d. Inside City Limits 1 文Yes 2 ☐ No
	with the	Direc	10e. Street and Number 41 N. Dacke	er Av	e.		-	10f. Zip Code 212	24			10g. Citi	zen of What C	ountry?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28e-f ahow aumatic event, It e Medical Examinations.	by Funeral Director	11. Marital Status 1 ★ Never Married 2 □ 3 □ Widowed 4 □ Divo		12. Was Deceder Armed Force 1 Yes 21 If Yes, Give Year or Dates	s? (No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🗷 No		gin? (Specify , Puerto Rica	Yes or No- an, etc.)		14. Race - Am Black, Whi Specify: Wh	ite, etc.
21215-0	1 within 72 ho jiene. r than "natur	Be Completed	15. Dec (Specify only in Elementary/Secondary (0-			r 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retir net Ma	during most ad)	t of working	1		nd of Business	ermarket
ryland ?	hould be filed d Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Min Unknown		iana Printi		10h 14ai6	Address (Constitution		unkn			,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any Injury or other traumatic. Once.		19a. Informant's Name/Rela Carl Chiver 20a. Method of Disposition 1 Burial 2 Corma 4 Donation 5 Oth 21. Signature of Funeral Se	a1 ion 3 □F er (Specify,	Removal from Stat	.0	421 Place of Disposementery, creative Wiew	S. Macconstitution (Name of matory or other place). Name and Address. Name and Address. Ol Dunce	on Sta	reet Date -3-20 Kaczo	Balt: 05 rowsl	imoi 20c.Lo Bal ki l	re, MI cation-City or Ltimor Funera	21224 Town, State 2e, MD al Home, PA
8760,	Physician /Medical Examiner	dical Examiner	23a. Part. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events resulting in death) Last	e, or comp List only o	ne cause on each	as a conseques a conseques a conseques	uence of):	·	phuls			rest,		Approximate Interval Between Onset and Death
O. Box 6	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t /	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta at time of d	Ideath 3[Ectopic pregnand Other (specify)	гу			2	3d. Date of de Month	livery Day Year
<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant col		ntributing to death	but not res	ulting in the u	nderlying cause g	ven in Part I.	_				o the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed									24a. Was a autops perform	SY.	24b. Were au prior to death? 1 ☐ Yes	utopsy findings available completion of cause of
of	Attending Physician: 1 r death. ector: Affer this certifical by the funeral director, p	ation; To Be	25. Was case referred to me examiner? 1 Yes 2 No 27. Manner of Death 1 Accident in	ŀ	Hospital: 1 ☐ Inpa 28a. Date of In (Month, D		ER/Outpatier 28b. Time of Injury	28c. Inju	her: 4 Nur	rsing Home 28d.	beck only on 5 ☐ Reside Describe ho	ence 6	☑Other (Spe	ocity) hospice
Division	in Diffe	Certification:		uld not be termined		njury - At ho etc. <i>(Specif</i>)		eet, factory, office		28f.	Location (St City or Town	reet and n, State)	Number or Ru	ural Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	edical	29a. Certifier 1 Cer (Check only 2 Med one)	ifying Phy ical Exami	sician: To the bes ner: On the basis and manner:	of examina	wledge, death tion and/or in-	occurred at the trestigation, in my	ime, date and opinion, death	d place, and h occurred a	due to the ca t the time, da	ause(s) a ate and	and manner as place, and due	s stated. a to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and TiNe of ce	titier) mo			29c. Licen	se number	1	2	9d. Date	signed (Mont	h, Day, Year)
1	/~		30. Name and address of pe	son who co	impleted cause of	death (Item	1 23a) (Type,	1 01	Bald	amor	e m	d.	217:	\2
	Sta Registr		31. Date filed (Month, Day,) MAR 0 7	ear)		trar's Signa	ture +	W.		TH SOL	, , ,			

		Amend Item#19b, per \$1,6841,3/7/05, Certificate of Death		2005	07401
	Dhysisian		2. Dete of Deeth		3. Time of Death
	Physician /Medical	4a Facility Name (If not institution give street and number) 4b. City, Town, or Loc	3 /	4c. County of Dee	0 - 7 3 7 .
	Examiner	4a Eacility Name (If not institution, give street and number) 4b. City, Town, or Loc ARK VIII.	110	Balt	imore
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Devs Hours Min	8. Date of Birth (Month, Day, Ye	9. Bi	rthplace (State or Foreign ountry)
	Director	Usuel Residence of Decedent		0 1	ew fork
	yland	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	tha Marylar 28a-f show notified at	MD BALTIMORE Parkville			1 □ Yes 2 No
	with the or 2	10e. Street and Number Blvd. Apt 2010 21234	10g.	Citizen of What C	ountry?
	aftar death with the Maryland or theme 23e or 28e-f show thiner must be notified at formal Director	11 Martiel Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - Am	
5	E 22 E	1 Never Married 2 Married 1 Yes 2 No	ilcari, etc.)	Black, Wh	6 4
21215.0020	72 hours aftar naturel; or te deal Exemine	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16h	o. Kind of Business	/Industry
215		(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College, (1-4or 5+)	g	Λ 6	00
1 5	tygian Rer th	17. Fether's Name (First, Middle, Last) 18. Mother's Name	(First Middle Mai	S Army C	exporting.
2 2	Mantal be financed of strice over the order over the order over th	Ernest Greene Lilla	Clar	k.	
Maryland Maryland	parmit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiena. Important: if Itam 27 is merked other than any injury or other traumatic event, the Magnes. To Be Compl	19a. Informant's Name/Relationship (Type, Print) 19b. Mail Telegraf Gree Pit (Amber or Rural	Route Number, C	ity or Town, State,	Zip Code)
)	and a laalth mast in ther tr	20a. Mathod of Disposition 20b. Place of Disposition (Name of	2010 Fa	Location - City o	MUDI239
A A A Series	agas nt of h	1 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)			
4 4	mit. Postma	4 Donation 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility P.A.	LTIMOR	E MO.	21234.
h a	Dama Dapa Impo	Kimberly G. Zantother Evans FUNERACHE			
0		23a. Part1. Enter the disease, or complications that acused the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,		Approximate Interval Between Onset and Death
3	Physician /Medical	Immediate Cause (Final			Oliset and Death
M	Ex miner	disease or condition resulting in death) Due to (or es a consequence of):			1
	in st. d				1
1	g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury			
.)	a ba a /slcian a buria	cause. Enter Underlying Cause (Disease or injury) that initiated events Due-to (or as a consequence of):			-
· ·	- 000				1
1	aath carti	d			
5 C	. D ap 6	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.			e to the cause of death?
2 0	s that as that gned to be date by P				
	a law raquira has baan sig ga 2 should b		24a. Wes an a performed		Were eutopsy findings available prior to completion of cause of deeth?
2 2	a law has b ga 2 s		4 🗆 Va.	0	
Vital		25. Wes cese referred to medical 26. Piece of Death	(Check only one)	21-1No	1 ☐ Yes 2 ☐ No
۲ کر ۱۷ کر		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	ne 5 Residence		ecify)
	lending Phaath. Or: Attar thi the funeral	1. Natural 5 □ Pending (Month, Day Year) Injury Work?	8d. Describe how i	injury occurred	
الله الله	or Attend aftar death Director: Jin by tha	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28	28f. Location (Stree City or Town, S		Rural Route Number,
ć	is aftar is aftar is Direction	4 ☐ Homicide building, efc. (Specify)	City of Town, 3	nate)	
	To the Hospital or Attending Physic within 24 hours after of asth. Completely filled in by the funeral director Attential or Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred and manner stated.	nd due to the caus d at the time, date	e(s) and manner e and place, and du	s stated. e to the cause(s)
	vithin 2 vithin 2 ompla	29b. Signature and title of certifier 29c. Libense number	29d.	Date signed (Mor	th, Day, Year)
	- > - 0	1) 1/4 1) 1/4 1/2		3/1/01	
	10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D Pa	Kalle	Md71234
1	State	31. Date filed Many Day, Transpage 32. Registrer's Sidesture	.)	- Juc	
	Registrar	Marin V I Could James Ja			

			1 - For State Registrar	State of Maryland		artment of H rtificate of L			ieńe 0 0 5	07402	2
	Physici	an	Decedent's Name (First, Middle, Last) DUTU		CEDC	ON		2. Date of Deat Month MARCH 2	D	3. Time of Deat	
	/Medic	al	RUTH 4a. Facility Name (If not institution, give st	reet and number)	GERS	4b. City, Town, or	Location of Death	MARCH Z	, 2005	3:00 A	М
	Examin	er	2 HIGHSTEPPER COU				BALTIMO	RE		BALTIMO	RE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, DEC.31,	Year) 9. Birth	place (State or For	eign
	Director		140-03-6062 Usual Residence of Decedent	[™] ² X 91	113.			DEC.31,	1913	NY	
	uryland show		10a. State 10b. County		Town or Lo	ocation				10d. Inside City Lin	
	the Ma	ecto	MD BALTI	MORE		10f. Zip Code	BALTIMO		Og. Citizen of What Cou	1 Tes 2 X	140
	3a or	ă	2 HIGHSTEPPER COU	IRT #403		101. Zip Code	21208	,	og. Citizen of What Cou	USA	
	ams 2	ıner		2. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Race - Amer Black, White	can Indian,	
36	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show ha Madical Exairatinatic matter matter	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1 □ Yes 2 🏋 No If Yes, Give Year or Dates:		1 □ Yes 2 🏹 No	Specify:		Specify:	WHITE	
8	2 hour	ted t	15. Decedent's Educa	ation		dent's Usual Occupa			16b. Kind of Business/II	ndustry	
7	ithin 7 ne. han "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Coilege (1-4or 5+)	life.	DO NOT use retired,))		OUN HOME		
d 22	filed w Hygiei ther ti	CO	17. Father's Name (First, Middle, Last)		HOME	MAKER	18. Mother's Nam		OWN HOME Maiden Sumame)		
au	2 should be filed and Mental Hygi is markad other aumetic event.	To Be	MAX		SCHW	ARTZ	ANNA		(UI)	IKNOWN)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumetic event. The Modical Experiment mat be notified at ance.		19a. Informant's Name/Relationship (Typ			-			City or Town, State, Zi		
	1 and Health am 27 thar tr		ARTHUR GERSON / S 20a. Method of Disposition	20b. Pla	ce of Disno	sition (Name of	1		MORE, MD 21 20c. Location - City or T		
TO T	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	metery, crei	on MEMORI	1		REISTERST(
Baltimore,	permit. F Departm Importar any injur		21. Signature of Puneral Service Licenses			2. Name and Addres			ON & BROS.		
<u> </u>	8958		and				ERSTOWN	ROAD - P	IKESVILLE,		
	Physician /Medical Examiner	er	23a. Part 1. Enter the dispase, or complic shock, or beart failure. List only one Immediate Carse (Final disease or crindition resulting in ath) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence)	((Fev				531,	Interval Between Onset and Death	1
8760,	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequent	ence of):						
Box 6	ath certif titending or use as	Physiclan/Me	in the past 12 months?	ic. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year	
P. 0.	that the de led by the a detached t	Phy	9 ☐ Unknown/ Part II. Other significant conditions cont	ributing to death but not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did tot	pacco use contribute to	he cause of death	?
ds,	luires tha n signed Ild be det	d by						1 □ Y€	es 2 0 0 3 □ Pro	bably 4 Dunkno	own
of Vital Records,		Completed						24a. Was a autops perform	y prior to co	opsy findings available on pletion of cause	able of
<u> </u>	Phyaician: Th r this certiticate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	nt 3□ DOA Othe		th (Check only on	e) ence 6 □Other (Speci		
on of	ting Phy n. Atter this funeral d	lon: To	27. Manner of Death 1 Natural 5 Pending		28b. Time o Injury	f 28c. Injury Work	at	/ \	ow injury occurred	77	
Division	al or Attanding Phyaician: s after death. Il Diractor: Atter this certitic id in by the funeral director,	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, sti		100 2010	28f. Location (St City or Town	reet and Number or Rui n, State)	al Route Number,	
	To tha Hospital or At within 24 hours after d To tha Funaral Diract completely filled in by	Medical C		ician: To the best of my know er: On the basis of examinati and manner stated.							
	To tha by within 24 To tha B complete	Me	29b. Signature and title of certifier	0 2 10		29c. License	number	2	9d. Date signed (Month)	Day, Year)	
)			30. Name and address of person who con	inpleted cause of death (Item	23a) (Tyne	Print	1543	d 1	larch 2,	2005	
(y		Tamara 5. Sobe	1, mp. 210	109	sveads 1	Dr. #c	100 C	wingsm	115 110	
	Sta Regist		31. Date filed (Many) (Name a) (Name a) 2005	3 Pagistrar's Sign	19	ww				21117	

			For State	State of I	Maryland	•	irtment of H		d Mental Hyg	2005	07100
			Registrar 1. Decedent's Name (First, Middle,	Last)		001	incate of L	Jean	2. Date of Dea	Reg. No. 🗸 🔰 💍	3. Time of Death
	Physici /Medic		GENYA			GI	NZBURG		MARCH	3 2005	2:00 A M
	Examin		4a. Facility Name (If not institution,	give street and numb	er)		4b. City, Town, or	Location of D	Peath	4c. County of Dea	
			MILFORD MANOR N			t birtholoss)	BALTIMO	ORE	Hrs. 9 Date of Birth	BALTIMORI	
	Funeral Director		5. Social Security Number 214-23-6398	6. Sex 7. 1 □ M 2 ☑ F	Age (In yrs. last	Yrs.	Months Days		Win. B. Date of Birth (Month, Day)	1911	thplace (State or Foreign puntry) RUSSIA
			Usual Residence of Decedent							,	
	show	_	10a. State 10b. County		10c. City, 7						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-1	Director	MD BA	ALTIMORE		BALI	IMORE 10f. Zip Code			10g. Citizen of What Co	
	3a or		1805 SNOW MEAU	OOW LANE #:	203			21209			RUSSIA
	ems 2	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. \	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin n. Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit	
36	i within 72 hours after death with the Maryland jiene. Tithen "natural", or items 23a or 28a-f show the Madical Examinar must be motified at the Madical Examinar must be motified at	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 If Yes, Give	X) No		I□Yes 21X No	Specify:		Specify:	WHITE
8	thour		15. Decedent	Year or Date s Education		16a. Deced	lent's Usual Occupa	ation		16b. Kind of Business	
215	hin 72 Bu "na Medi	Completed	(Specify only highest	t grade completed) College (1-4)	or 5+)	life. I	kind of work done of OO NOT use retired	during most of ()	working		
21	e filed within I Hygiene. other than "	Соп	Elementary/Secondary (0-12)			HOME	MAKER	10 11-11-1-	Name (First, Middle,	OWN HOME	
Maryland 21215-0036	e d la be) Be	17. Father's Name (First, Middle, L LAZAR	ast)		GECH	MΔN	GITE		· ·	ORELIK
ary	d 2 should be th and Mental I 7 is marked o treumatic eve	ဥ	19a. Informant's Name/Relationsh	ip (Type, Print)						r, City or Town, State,	
	alth a		LEONID MZHEN ,	/ GRANDSON		- 4		STONE	ROAD - SYK	KESVILLE, M	D 21784
Baltimore,	S == = 0		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from St	ate cem	etery, crer	sition (Name of natory or other plac	1		20c. Location - City or	
Ē			* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		CHIZU		UNO ARLIN			BALTIMOR	
Ba	permit. Departr importe any inju		Total /							SON & BROS. PIKESVILLE.	
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cau	sed the death.						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	ATHE	ROSCI	VER	OTIC (ARD	IDVASCU	HAR DIS	nset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequer	nce of):					
		e.	Sequentially list conditions,	b. — Dua to (or	as a conseque	tea of).					
	outed id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	G							
,00	be executed sician and burial-transit	Exc	resulting in death) Last	Due to (or	as a consequer	nce of):					
8760	the the	dical		d.							
Box 6	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			Je			23d. Date of de	livery
	death ne atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		h 2 ∏ Fetal de nt at time of deat m		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the de ed by the a detached	Phy	9 ☐ Unknown Part II. Other significent conditio			ng in the u	nderhing cause gru	on in Part I	23e Did to	obacco use contribute to	o the cause of death?
ds,	signe d be c	d by	Faith. Dillet significant condition	na contributing to dou	ar bat not room	ing in the c	ndonying oddao giv	OIT II T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			robably 4 Donknown
ecords,	w require been si should I	lete							24a. Was a		utopsy findings available
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Vital	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					-	Death (Check only or	пв)	
of V	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☐ No		patient 2 EF			Peursi	-	dence 6 Other (Spe	cify)
on	fer fer	tion	27. Manner of Death Natural 5 Pending 2 Accident investig	9	Day Year)	Bb. Time o Injury	Worl	yat k? Yes 2 ∐ No		low injury occurred	
Division	Attending at death. eclor: After by the fune	Certification:	3 Suicide 6 Could n	ot be 28e. Place of	f Injury - At hom	e, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number or R	ural Route Number,
Ö	itel or rs afte rei Dir lled in										
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical			is of examination					cause(s) and manner a date and place, and du	
	To the Within To the	Me	29b. Signature and title of certifier				29c. License			29d. Date signed (Mon	th, Day, Year)
	d		1 Jasue	em 46	rllia	<i></i>	1) 8	2859	5-	3/3/05-	pa.
,	1		20 Name and address of person	who completed cause	of death (Item 2	3a) (Туре, 220	Print) PARK	HE1	S- Gotts An	E BAU	DMD 21208
•	Sta		31. Date filed (Month, Day, Year)	32. Rec	istrar's Signatur	e 4	1				
	Regist	rai	10 224	7 2005	BURLES A	J. 16	pare				

		Flease	01.1					
		1 _ For State	State of Maryland /			ental Hygie		07101
		Registrar		Certificate of			No.2005	0/404
		1. Decedent's Name (First, Middle, La	ist)			Date of Death Month	Day Co Year	3. Time of Death
Phys	dical	Arthur Lawrence	Gudwin, M.D.		[1	Mar.	1, 2005	1:20 p M
	niner	4a. Facility Name (If not institution, give	re street and number)	4b. City, Town, o	r Location of Death		4c. County ol Death	
		Anne Arundel Me	edical Center	Anna	apolis		Anne Aru	ndel
Funer	al	Social Security Number 6.5		irthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jul. 14,	9. Birth	olace (State or Foreign
Directo	or	101–30–0277	1 ™ 2□ F 67	Yrs.	, rours	Jul. 14,	1937	NY NY
P .		Usual Residence of Decedent	40- Ch. T.					10.1 1 11 (2) 11 11
urylar show		10a. State 10b. County		wn or Location	Dowle			10d. Inside City Limits
e Ma	용	MD Anne A	rundel	Severna	Palk			1 ☐ Yes 2X No
or 2	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Coul	ntry?
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23e or 28e-f show avent, Item Medical Exercitive Trivial to Indifical at	<u>0</u>	3 Cedar Point Ro	ad		21146		USA	
r dea	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of F If Yes, specify Cub. 	lispanic Origin? (Spec an, Mexican, Puerto P	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
o affer and	丘	1 ☐ Never Married 2 🔀 Married	1 XYes 2 No		Specify:			White
within 72 hours after ene. then "natural", or its ite medical Exercises.	d by	3 Widowed 4 Divorced	Year or Dates: VIECHAII					
72 t an	Completed	15. Decedent's E (Specify only highest gr.	ducation 16a ade completed) ·	 Decedent's Usual Occup (Give kind of work done 	during most of workin	16t	o. Kind of Business/In	dustry
He is in the second	d E	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire			Modiain	
TO ZIZI e filed within al Hygiene. I other than '	ပိ	47. Esthada Nama /First Adiddla Jaco	5+	General S	18. Mother's Name	/First Adddlo Adsi	Medicin	<u> </u>
d be file bental Hy ked oth c avent	Be	17. Father's Name (First, Middle, Last					den Sumame)	
naryian 2 should be 1 and Mental 1s marked (2	Morris Gudwin, M			Ethel Mo			
re, Maryla s 1 and 2 should f Health and Men item 27 is marke other traumetic		19a. Informant's Name/Relationship		b. Mailing Address (Street			•	146
ore, IVI		Patricia Gudwin/		3 Cedar Poin				
or of H		20a. Method of Disposition 1 Burial 2 Cremation 3		of Disposition (Name of ery, crematory or other plan	Mar.	2.	. Location - City or To	
Pag ment ent: ury c		`4 □Donation 5 □Other (Speci	Metro	o Crematory		005	Baltimore,	MD
Daltimor permit. Pages Department of the Important: If ite any injury or of	- BOUCE	21. Signature of Funeral Service Lice	ngee	Barranco	Sons, P.	A. Severi	na Park Fu	neral Home
D 90F#	a	LAMOS COLL	arsonce	495 Gov. 1	Ritchie Hw	y, Severi	na Park, M	D 21146
		23a. Part1. Enter the disease or con shock or heart failure. List only	oplications that caused the death. Do	not enter the mode of dyir	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
Physicia	ın	Immediate Cause (Final		toma n				Onset and Death
/Medic	al	resulting in death)	a Due to (or as a consequence					, , , , , , ,
Examine	er							
	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of):				
cuted	Examiner	Cause (Disease or injury that initiated events	C.					
O, exec an ar rial-tu	EX	resulting in death) Last	Due to (or as a consequence	of):				
ecords, P.O. BOX 68/60, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cai		d					
od tifical g phy as th	ed						1	
ath cer attendin for use	N/C	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	h 3 Ectopic pregnance	,		23d. Date of delive	,
death death	<u>S</u>	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death	5 Other (specify)			Month	Day Year
of the ache	Physician/Med	9 Unknown	9□ Unknown					
s tha ned l	by P	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause give	en in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
cords w requires been sign should be	9	WA often	martin for	malynn	4	1 🗆 Yes	2 No 3 Prot	ably 4 Unknown
w w rec	Completed	hi a	timor			24a. Was an	24b. Were auto	psy findings available
	E	- Com	V 0 V) V 1 V			autopsy performed	? death?	mpletion of cause of
he tare he tare he tare he tare has has	ပိ				00 51 (5-4)	1 ☐ Yes 2 🗶	No 1 □ Yes	2LJ No
The ate h		OF Mes sees referred to modical			26. Place of Death		2 57011 (2 /2	
The ate h	Be	25. Was case referred to medical examiner?	Hospital:	Oth		ie 5∐ Hesiden¢	e 6 ⊟Other (Specif	V)
The ate h	To Be		1 Dunpatient 2 EH/C		4 Nursing Hon	8d. Describe how i	niury occurred	
The ate h	tion; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending	28a. Date of Injury (Month, Day Year)	Time of Injury Wor	y at k?	8d. Describe how i	njury occurred	···
The ate h	ication; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not by	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury M 1	y at k? Yes 2 No			
The ate h	ertification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury M 1	y at k? Yes 2 No		t and Number or Rura	
The ate h	al Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determined	28a. Date of Injury 28b. (Month, Day Year) 28b. Place of Injury - At home, 1 building, etc. (Specify)	Imparent 3 BOA 28c. Injury Wor 1 1 1 1 1 1 1 1 1	y at 2 k? Yes 2 No 2	8f. Location (Stree City or Town, S	t and Number or Rura tate)	ul Route Number,
The ate h	dical Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatic 3 Suicide 6 Could not be determined. 29a. Certifier 1 Certifying P	28a. Date of Injury - At home, 1	Time of Injury M 28c. Injury Wor 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	y at y at y at Yes 2 No 2	8f. Location (Stree City or Town, S	t and Number or Rura tate) e(s) and manner as s	d Route Number,
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Of Vital Ri Physician: The ribis certificate heral director, page	Medical Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigation 2 Accident 6 Could not to determined 29a. Certifier (Check only one) 1 Certifying P (Check only one)	28a. Date of Injury - At home, in 28b. Place of Inj	Time of Injury Mon M 1 28c. Injury Work M 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	y at k? Yes 2 No 2 me, date and place, a pinion, death occurre se number	8f. Location (Stree City or Town, S and due to the cause d at the time, date	t and Number or Rura tate) e(s) and manner as s and place, and due to	tated. b the cause(s) Day, Year)
The ate h	Medical Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigation 2 Accident 6 Could not to determined 29a. Certifier 1 Certifying P (Check only one) 29b. Signature and title of certifier	28a. Date of Injury 28b. 28a. Place of Injury - At home, in building, etc. (Specify) hysician: To the best of my knowledgeminer: On the basis of examination a and manner stated.	Injury M 28c. Injury Wol M 1 1 28c. Injury Wol M 1 28c. Injury Wol	y at k? Yes 2 No 2 me, date and place, a pinion, death occurre to number	8f. Location (Stree City or Town, S and due to the caus d at the time, date	e(s) and manner as sand place, and due to Date signed (Month,	tated. the cause(s) Day, Year)
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director. After this certificate h. To the Funerel Director. After this certificate h.	Medical Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigation of the determined of the	28a. Date of Injury - At home, to building, etc. (Specify) 28b. Place of Injury - At home, to building, etc. (Specify) hysician: To the best of my knowledgminer: On the basis of examination a and manner stated.	Injury M 28c. Injury Wol M 1 1 28c. Injury Wol M 1 28c. Injury Wol	y at k? Yes 2 No 2 me, date and place, a pinion, death occurre se number	8f. Location (Stree City or Town, S and due to the caus d at the time, date	e(s) and manner as sand place, and due to Date signed (Month,	tated. the cause(s) Day, Year)

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005
>	Physici /Medi Examir	al	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year March 03, 2005 2:10 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral Director		70Nh 5 Moptins 74 y (Liu) Medical Uniter Daltimore (ity 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. (Month, Day, Year) 9. Birthplace (State or Bireign Month) Days Hours Min. (Month, Day, Year) Feb10, 1919 Virginia Usual Residence of Decedent
	72 hours after death with the Maryland neturel; or Items 23a or 28a-f show disal Examinative Invitted at	ector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□Yes 2√□No
	death with the ms 23a or 2	Funeral Director	106. Street and Number 107. Zip Code 108. Citizen of What Country? 109. Citizen of What Country? 109. Citizen of What Country? USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
9000	n 72 hours after death with the Marylan "neturel", or Items 23a or 28a-f show idleal Examinat he indiffed at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White
d 21215-0036	filed within Hygiene. Ither then "	e Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th 17. Father's Name (First, Middle, Last) (unk) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Worker 18. Mother's Name (First, Middle, Maiden Sumame) (unk)
Maryland	12 should h and Men 7 is marke treumatic	To Be	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 Brookview Road Dundalk, Md 21222
Baltimore,	ermit. Pages 1 and Bepartment of Healt mportent: If Item 2 ny injury or other nce.		20a. Method of Disposition Date Control of Disposition
Ba	Depa Impo eny i		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate
8760,	Medical Examine by sician and bhysician and street burial-transit	dlcal Examiner	shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Conset and Deat
P.O. Box 6	that the death certific ed by the attending pi detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 roenths? 1
Vital Records, P	v requires been sign should be	Completed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus, Endocard is, Pericandits, 1 yes 2 No 3 probably 4 Unknown Embalic CVA: (Nyman Tvat Trufe to the cause of death?
Vital Re	sician: certifica rector, p	o Be Com	autopsy performed? performed? performed?
Division of	tending leath. tor: After the funer	Certification: To	1 Yes 2 No
_	Hospito 4 hours Funere	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	To the within 2 To the complete	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) March 3, 2005
10	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Horking Bay View Med. Ctv 4940 Eastern Are, Baltimore, MD 21224 31. Date filed (Mohit, Day, Year) 32. Togistrar's Signature MAR 0 7 2005
	- 7		MARIE O 1 E000 PERMINE NO.

			1 - State Registrar	doc			d / Depa	artment of rtificate of	Health a	and M	ental Hyg	_	noie.	071.00
	Dis		1. Decedent's Name (First, Min	ddle, Las	it)						2. Date of Deat Month		Year	3. Time of Death
d l	Physici /Medic		Lenwood				Harı	is			Februar	y 26,	2005	3:30 PM
	Examin	er	4a. Facility Name (If not institu					4b. City, Town,					ty of Death	
			Holy Cross 1 5. Social Security Number	6. Se		r 7. Age (In yrs.	last hirthday	Burton			8. Date of Birth	Mont	gomer	
	Funeral Director		228-34-3030 Usual Residence of Decedent		₽M 2□F	75	Yrs.	Months Days		Min.	July 9,	^Y 1929	Virg	lace (State or Foreign try) inia
	ow ow		10a. State 10b. Cour	nty		10c. Cit	y, Town or Lo	cation					1	Od. Inside City Limits
	Many a-f sh	tor	MD Prin	ce (George's	Воз	wie							1 ☐ Yes 2 ₹ No
	th the	Director	10e. Street and Number					10f. Zip Code			16	og. Citizen of	What Coun	try?
	ath w	rall	606 Jennings	Mil1				20721				USA		
	er de Itams	Funeral	11. Marital Status 1 □ Never Married 2 🔀 M	and and	12. Was Deced	ces?		Was Decedent of f Yes, specify Cul	Hispanic Ori ban, Mexicai	igin? (Spe n, Puerto i	cify Yes or No- Rican, etc.)		ice - Americ ack, White,	
336	urs aft	ρ	3 ☐ Widowed 4 ☐ Divord		If Yes, Give Year or Da	^{2□No} Kore ^{tes:} Conf	an	1 ☐ Yes 2 📉 No	Specify:			Speci	ify: B	lack
2-0	72 hours after death with the Maryland Insturet; or Itams 23e or 28e-f show Jisel Evantret must be notified at	Completed	15. Decec (Specify only hig		ucation	COIII	16a, Deced	dent's Usual Occu	pation	et of worki	7.0	16b. Kind of I		
21	within a ene.	nple	Elementary/Secondary (0-12		College (1-	4or 5+)		kind of work done DO NOT use retir						
121	be filed within 72 hours after death with the Marylan lat Hygliene. Id other than "natural", or Itams 23a or 28a-f show event, the Medical Evantral must be notified at		17. Father's Name (First, Midd	lo (ast)	2		Main	tenance	-		(First, Middle, N			vernment
anc) Be	Lennie Harris							y Lew		aloen Suma	me)	
Maryland 21215-0036	d 2 should th and Men ?7 Is marka traumatic	²	19a. Informant's Name/Relation		ype, Print)		19b. Mailir	ng Address (Stree				City or Town	n, State, Zip	Code)
Ĭ	C/ G = 68		Alice D. Harr	is -	Wife			Jennin						
ore,	es 1 a of He of He fitam roth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic		Domousi from S	20b. P	tace of Dispo	sition (Name of natory or other pla	ace)	D	ate 2	20c. Location	- City or To	wn, State
ij	Pag ment ant: b		4 Donation 5 Other			Har		mily Cem	1	3-6-6		Lorne,	VA	
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar tr		21. Signature of Fineral Servi	ce Licen.	see	200	22	Name and Addr	ass of Facilit	y Fun	eral Hor	ne		
	405 9 Q		23a. Part1. Enter the disease,	0.44	vications that ca	ULL L		P.O. Bo	<u>ж 11 І</u>	Port_	Royal, V	VA 225	35	Approximate
	Physician /Medical Examiner	ler	shook, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ist only o	a. Meta Due to (o		uence of):	lodgkin's	s Lymp	homa				Interval Between Onset and Death
68760, <	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	J	c	or as a consequ	uence of):							
P.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			th 2 Fetal int at time of de	Ideath 3	Ectopic pregnand Other (specify)	;y			1	ate of deliver	ry Day Year
Ś	S	by	Part II. Other significant cond	itions co	ontributing to dea	ath but not resu	ulting in the u	nderlying cause g	ven in Part I.					e cause of death?
Record	> 10	olete									24a. Was an		Were autop	esy findings available
-	The ate h page	Completed									autopsy perform 1 Yes 2	ed?	prior to con death? 1 Yes	npletion of cause of 2 No
Vital	Physician: The this certificate rai director, pag	Be	25. Was case referred to medi examiner?	-	Hospital:			0:	han		(Check only one			
of		on: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pen	-	1 □ In 28a. Date of (Month		ER/Outpatien 28b. Time of Injury	28c. Inju	at ork?	2	ne 5 Resider)
=	or Atter fter dea iractor n by the	Certification:	3 ☐ Suicide 6 ☐ Cou	stigation ld not be rmined	289. Place C	of Injury - At ho g, etc. <i>(Specif</i> y	ome, farm, stre	M 1 [Yes 2	-	8f. Location (Str. City or Town,		ber or Rural	Route Number,
_	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical Ce	(Uneck only 2 Medic	ying Phy al Exam	uner: On the bas	sis of examinal	wledge, death	occurred at the trestigation, in my	ime, date an opinion, dea	d place, a	nd due to the car	use(s) and m te and place,	anner as sta	ited. the cause(s)
	o the ithin 2 o tha omple	Med	one) 29b. Signature and title of certi	fier	and manne	stated.		29c. Licen	se number		29	d. Date signe	ed (Month, D	Day, Year)
	F 5 F 0		1 alan	L	lea	al	M	D52	261				-28-05	
_	5		30. Name and address of personal R. Sega	1, M	D C	1500	Fores	Print) st Glen]	Rd. Si	.lver	Spring,	MD 20	910	
	Sta Registr		31. Date filed (Month, Day, Ye	2008	62. Re	gistrar's Signa	ture	12						

Physici	an	1. Decedent's Name (First, Middle, Last)		11	2. Date of Death Month	Day Year
/Medic	al	WILLIam		Hogsard	February	
Examir	er	4a. Facility Name (If not institution, give s	treet and number)	46 Cff, Town, or Location of Death	10.	4c. County of Death
		5. Social Security Number 6. Sex	7. Age (In yrs. last)	or Carty Meycel pirthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	N/A
Funeral Director		219 26 9546	₹ 65	Yrs. Months Days Hours Min.	OCT. I	9. Birthplace (State or Country) MARYLAND
		Usual Residence of Decedent				
show	<u>_</u>	10a. State 10b. County		wn or Location		10d. Inside City
188-f	Director	MD N/Z	BALTIN			1 X Yes 3
a or		10e. Street and Number 5214 KELWAY ROAD		10f. Zip Code 21239		g. Citizen of What Country?
ital Hygiene. id other than "naturel", or items 23a or 28e-f sho event, the Madical Exarimetr sast be notified at	Funeral		2. Was Decedent Ever in U.S.			14. Race - American Indian,
or Iter	Έ	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 XYes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
rel', o	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No Specify:		Specify: BLACK
natu	Completed	15. Decedent's Educ (Specify only highest grade	cation 16 completed)	a. Decedent's Usual Occupation (Give kind of work done during most of work	ring 10	6b. Kind of Business/Industry
han.	ш	12th	College (1-4or 5+)	life. DO NOT use retired) TO MECHANIC	C	
Hygiene. ther that		17. Father's Name (First, Middle, Last)	PAC		e (First, Middle, Ma	ELF EMPLOYED
arked o	To Be	JOHNNIE HOGGARD			, , ,	and defination
2 E E	-	19a. Informant's Name/Relationship (Ty)	pe, Print) 19	MAMIE ASK 9b. Mailing Address (Street and Number or Rur		City or Town, State, Zip Code)
tem 27 is		BEULAH J. HOGGARD (WIFE) 5	3214 KELWAY RD. BALTIM	ORE MAR	YLAND 21239
f item r othe		20a. Method of Disposition	20b. Place			Oc. Location - City or Town, State
ant: If i		1 🔀 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State CROWN	SVILLE CEMETERY MARCH	8, 2005	BALTO, MARYLAND
Department of Importent: If i eny injury or once.		21. Signature of Funeral Service License	18	22. Name and Address of Facility CA	LVIN B.	SCRUGGS FUNERAL H
2 = 9 9		(des)	The	1412 E. PRESTON STR		
ysician Medical aminer	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underrying Cause (Disease or injury that initiated events	Due to (or as a consequence	e of):		yeors
physician and s the burial-transit	icai	resulting in death) Last	Due to (or as a consequenc	e of):		
the attending p	Physician/Med	in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Ye
a o	Phy	9 Unknown				
been signed t should be det	ted by	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in Part I.	İ	cco use contribute to the cause of de
ate has page 2	e Completed	25. Was case referred to medical		26 Place of Deat	24a. Was an autopsy performs 1 Yes 2 in Check onlone	No 1 ☐ Yes 2 ☐ No
5 0	To B	examiner? 1 □Xes 2 □ No	ospital: 1 Inpatient 2 DER/C	0.0		ce 6 Dether (Specify) home C
deatn. stor: After th		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b		28d. Describe how	
in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Numbe State)
uner uner ly fill	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	ician: To the best of my knowled her: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the cau red at the time, dat	ise(s) and manner as stated. e and place, and due to the cause(s)
the F	- 5	29b. Signature and title of certifier	,	29c. License number	290	d. Date signed (Month, Day, Year)
within 24 hours a To the Funerel I completely filled	-	1)	. / / / /			
within 24 hours a To the Funerel C completely filled		I leter M.	the , MD	D53368 1) (Type. Print) th Wolce St. Bald	A	Parch 4, 2005

			For	State of Marylan	d / Depa	artment of I		-	_	
			= State Registrar		Cei	rtificate of	Death		. No.2 0 0 5	07408
	Physic /Medi		1. Decedent's Name (First, Middle, La. Gilbert	Jacobs				2. Date of Death Month February	Day Year	5 12 2 PMM
	Exami	ner	4a. Facility Name (If not institution, giv. Northwest Hos	spital Center	,	0 1	or Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. i		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltimo	rthplace (State or Foreign country)
	Director		219-76-4864 Usual Residence of Decedent	13xM 2□ F 55	Yrs.	Months Days	Hours Min.	(Month, Day, Ye March 11	ear) 1949 C	Maryland
	r 28a-f show	_	10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	the M.	ecto	MD Ba1 10e. Street and Number	timore			ndallstown			1 ☐ Yes 2 ☑ No
	ath with s 23s or	Funeral Director	200 Rosewood La	ne		10f. Zip Code	117	10g.	. Citizen of What C	ountry?
	death	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \		Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
21215-0036	72 hours after death with the Maryland naturel', or Items 23s or 28s-f show alcul Examinan must be maiffed at	by	1 1 1 Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		rres, speciny cub I⊡ Yes 2.2XNo		Hican, etc.)	Black, Whi	ite, etc. White
5-0	72 hours "naturel".	Completed	15. Decedent's Ec (Specify only highest gra		16a. Deced	lent's Usual Occup	oation during most of working)	na 16t	o. Kind of Business	s/Industry
121		ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	Disable Disable				
	Hygi Hygi other ent. I	a)	17. Father's Name (First, Middle, Last)			DISAULE		(First, Middle, Mai	den Sumame)	
<u>la</u>		ToB	Daniel	Jacobs			G1	advs		
Maryland	2 8 8 9		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailin	g Address (Street	and Number or Rura		ity or Town, State,	Zip Code)
	is 1 and of Health item 27 other tr		Jeffrey L. Jac 20a. Method of Disposition			Eastside		Tacoma,		
Jor	m O		1 ☐ Burial 2 XI Cremation 3 ☐	nomoval mom State		sition (Name of natory or other place			c. Location - City or	
Baltimore,	permit. Page Department Importent: If eny injury or once.	li	4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen				Ser 3/2/		Hampstea	d, Maryland
B	permi Depa Impo eny ii		Stop low	M Lenkin	E.	line Fune	eral Home	Reisterst	erstown K town. Mar	yland 21136
	Pnysician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	olications that caused the death one cause on each line.	. Do not ente	er the mode of dyir	ng, such as cardiac o	Syndro		Approximate Interval Between Onset and Death
	Examiner	er		Duf to (or as a consequence Gram negation Due to (or as a consequence Due to (or a consequence Due to (or a) (or a consequence Due to (or a) (or a) (or a) (or a) (or a) (ve p	neuman	100			>5 days
	icate be executed physician and s the burial-transit	Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. R Due to (or as a consequ	Oli Dari	otion				>5 days
68760	icate be o physicial s the buri	ical		a Neurogeni	c dy	sphajia				> 1 month
P.O. Box (The law requires that the death certificate be execut to has been signed by the attending physician and bage 2 should be detached for use as the burial-tran	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
	w requires that been signed t should be deta	by	Part 11. Other significant conditions co Mental retardation		lting in the un	derlying cause giv	en in Part I.	23e. Did tobacc	./	the cause of death?
eco	ie taw requ has been ge 2 should	Completed	Seizure disorder					24a. Was an	24b. Were at	utopsy findings available
E.	The cate h page	Com	Immobility sur	idrome				autopsy performed	? death?	completion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ton	26. Place of Death	(Check only one)		
of	Phys r this ral dii	1: To	1 Yes 2 No 27. Manger of Death	1 Inpatient 2 E	R/Outpatient 28b. Time of		4 LI Nut Sing Hon	ne 5 Residence		cify)
ion	nding ath. r: Afte e fune	atlor	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Worl	k? Yes 2 □ No	.se. Describe non i	ijary occurred	
Division of Vital Records,	al or Atter after des I Director d in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, factory, office	2	8f. Location (Street City or Town, St	and Number or Ru ate)	ural Route Number,
•	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Phyone) Check only 2 Medical Exam	vsician: To the best of my know iner: On the basis of examinati and manner stated.	rledge, death on and/or inv	occurred at the tin estigation, in my of	ne, date and place, a pinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To To t		29b. Signature and title of certifier Booton A	ND			8462		bruary o	n, Day, Year) 27, 2005
_	b			Jorthwest	Hospi	tal K	Candallst	town. A	Narylan	d 21133
38-42	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 7 2	32. Registrar's Signatu	H. A	barte		,		

			For State Registrar	State of	f Marylaı	•		t of H	ealth a	and M	lental Hy		200	5	07409
			1. Decedent's Name (First, Middle, La	st)					-		2. Date of De Month	ath Da		ar	3. Time of Death
	Physici /Medic		Nedka Kalinov	Kantor	, Ph. [).					March 5	5, 2	005 '	ar	11:50am [™]
	Examin		4a. Facility Name (If not institution, giv.	e street and nun	nber)		4b. City,	Town, or	Location of			4c	. County of I		
			Greater Baltimon	e Medic	al Cen	ter	Tows	on				В	altimo	ore	
	Funeral		5 Social Security Number 6 S	AX		. last birthday	If Under		If Under	24 Hrs. Min.	8. Date of Bir	th Vear	9.	Birthplac	e (State or Foreign
	Director		070-42-6892	_M 2 ₹ F	83	Yrs.	Months	Days	Hours	Mun.	8. Date of Bir (Month Da April	15,	1921	Bu	lgaria
-	P .		Usual Residence of Decedent												
	inylar show	_	10a. State 10b. County			ity, Town or L								10d.	Inside City Limits
	Ba-f s	5	MD n/a		Ba	altimor	e Cit	y							¹√Yes 2□No
	or 26	Oire	10e. Street and Number				10f. Zip					-	tizen of Wha	t Country	?
	death with the Maryland rms 23e or 28e-f show rmust be invitted at	by Funeral Director	111 Hamlet Hill	Road #51	10			210				US	iA		
	r deg	ne	11. Marital Status	12. Was Dece Armed For	rces?	U.S. 13.	Was Deced If Yes, spec	dent of Hi	ispanic Ori n, Mexicar	gin? (Spen, Puerto	ecify Yes or No Rican, etc.))-	14. Race - A	American White, etc	
36	or Ite	Y.	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	8		1 ☐ Yes						Specify:	W	hite
\angle 8	n 72 hours after de *natural', or Item: edical Examinar n	d b	3 ₩idowed 4 Divorced	Year or Da	at <i>e</i> s:	1 10 5									
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121	within 72 ene. than *nat	Completed	Elementary/Secondary (0-12)	College (1 5+	-4or 5+)		essor		,			Mor	gan S	tete	Univ
22	e filed within I Hygiene. other than vent, the M	ပိ	17. Father's Name (First, Middle, Last,			1 1 1 0 1	69901		18. Mothe	er's Name	(First, Middle			00.00	OHIZO:
⊸ a i	ntal	To Be	Dimitr Kalino						Mar:		Mink		, , , , , , , , , , , , , , , , , , , ,		
<u>- 2</u>	should by ord Menta	F	19a. Informant's Name/Relationship (19h Mail	ing Address	(Street :			I Route Numb	er City r	or Town Sta	te Zin Co	nde)
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e,	s 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the M		Dr. Ruth Ellen K 20a. Method of Disposition	antor/o		Place of Disp	Diamo	ne of	1		Balti Date		ocation - Cit	2120 or Town	
Sie	Pages nent of int: If it iry or o		1 XBurial 2 Cremation 3		State	cemetery, cre uid Ri	matory or o Ldge	ther plac	e) [73/12	2/2005	Pik	esvil	le N	4D
kantor, $Nedka$ Baltimore, Maryland 21215-0036	mit. Pa bartmen cortant: injury	U.	*4 □Donation 5 □ Other (Specifical Structure of Funeral Service Kicel		DI		-	d Addres							
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			23a. Part1. Enter the disease, or com	Stepher							DWSON,		Tand		+ oproximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on e	ach line.									ln:	terval Between nset and Death
	Pnysician /Medical		disease or condition resulting in death)				LG 22 V	a (Mer	n01	rhag	7-6		19	hours
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#	ecuted and I-transit	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
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760	te be executecysicien and le burial-transi	cai		d											
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Box 68	leath certificat attending phy I for use as th	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			75					- 1	23d. Date of	delivery	
m	death e atte d for	icla	in the past 12 months? 1 □ Yes 2 □ No	4□Pregn	irth 2□Fet ant at time of		⊒Ectopic pr ⊒ Oth <i>e</i> r (sp						Month	Da	y Year
P.O.	at the de by the a tached f	hys	9 Unknown	9□ Unkno	own										
<u></u>	The law requires that the death certifica are has been signed by the attending pt page 2 should be detached for use as it	by Physician/Med	Part II. Other significant conditions of	contributing to de	ath but not re	sulting in the i	underlying c	ause give	en in Part I.		23a. Did t	obacco i	use contribu	te to the d	ause of death?
Ę	w require been sig should b										1 🗆 '	Yes 2	12H0 3[Probabi	y 4 □Unknown
္မ	s bee	Set									24a. Was		24b. Wer	e autopsy	findings available
Re	sician: The law certificate has i irector, page 2 s	Completed										rmed?	prior	r to compl h?	etion of cause of
ta	ifficat	Ö	25. Was case referred to medical						26 Place	of Death	1 Yes		1	Yes 2	
5	Physician: rthis certifica ral director, p	To B	examiner? 1 Yes 2 40	Hospital: 1	npatient 2[☐ ER/Outpatie	nt 3□ DC	Othe			me 5 ☐ Resi		6 □Other (Specify)	
ō	Ph)		27. Manner Jeath	28a. Date o	of Injury	28b. Time		8c. Injury Work		-	28d. Describe			open,y,	
<u>0</u>	Attending For death. ector: After by the funer	atio	1 □ atural 5 □ Pending 2 □ Accident investigatio		h, Day Year)	Injury	м		<br Yes 2 □.	No					
Division of Vital Records,	Attendi r death. ector: A by the fu	Certification:	3 Suicide 6 Could not be determined	288 Place	of Injury - At I	home, farm, si	reet, factory	, office			28f. Location (. City or Tox	Street an	d Number o	r Rural R	oute Number,
۵	s afte	Sert	4 Nomicide	Dullali	ng, atc. (Spac	.11 y)					City of Tol	WII, SIGIO	"		
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Pt												
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by tt	edical	(Check only 2 Medical Examone)		asis of examin ner stated.	ration and/or if				uti occurr	ou at the time,	Jate and	place, and	due to the	e cause(s)
	To t To t	Σ	29b. Signature and title of certifier	~					e number			29d. Da	te sign <i>e</i> d (N	fonth, Day	v, Year)
			1) House	reme	NO)	10	2	47.	32		5/6	5/05		
	17		30. Name and address of person who	completed caus	e of death (Ite	em 23a) (Type	, Print)		- 1					_	
II <u>.</u>	10				1.0.	2/0	Nes	4 1	20,	10	200	7	Me	2	1204
	Sta Regist		31. Date filed MARTIN (1) y. 7 ea 101		agistrar's agr	natur									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** February 2330 110 23 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death Examiner Ma 5. Social Security Number 20 7. Age (In yrs. last birthday) If Under 24 Hrs. 6/Sex If Under 1 Year 8. Date of Birth (Month, Day, Year) |-2-14 **Funeral** Birthplace (State or Foreign Country) -22-9682 1 M 200 F Days Months Min **Director** Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County Show 10c. City, Town or Location 10d. Inside City Limits ir than "naturaf, or items 23a or 28a-f shoi the Medical Examinar must be notified at Be Completed by Funeral Director 1 ☐ Yes 2 No Har 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced Specify: White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) oncenake d other traumatic event. 17. Father's Name (First, Middle, Last), 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H is marked of JAMES ockernam avra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health as Important: If item 27 is any injury or other trac 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Marvew 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) William Waters Come terry LorestHi 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FURLOT HILL MO 21050 3 NEWPORT DR Frans Funcial Chapel-Bel Air. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Recemonea /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): Box IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔊 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 INo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Vital 2 No 2 (No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending Injury NOPP, 1 ☐ Yes 2 ☐ No withir 24 hours after death. To the Funeral Cirector: A 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide dical Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0056607 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #602 BELASRIND, 21014 ANGELO S-ATWOOD #205 1025bh 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar

amend Trem#17, perfn, 69 1,3/7/05 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year C. EUNICE KLEIN MARCH 2005 7:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕡 F Director 100 Yrs. OCT.10,1904 117-10-0746 NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral', or items 23a or 28e-f show Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 MT. WILSON LANE 21208 USA Funeral Pages 1 and 2 should be filled within 72 hours efter death nent of Health and Mental Hyglene.
and: If item 27 is marked other than "natural", or Items 23.
ury or other treumatic event, in a Madical Estantinal must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Completed by Specify: 3 X Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIETICIAN NURSING HOMES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SIMON COHEN Α ZELLA 2 IVESHKOVSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 DEER RIDGE DRIVE #212 - BALTIMORE, MD 21210 JANET BROWN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🛱 Removal from State permit. Page Deportment of Importent: If any njury or once * 4 ☐ Donation 5 ☐ Other (Specify) DEGEL ISRAEL CONG. 03/06/2005 WATERTOWN, NY 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): adiovancular Examiner clerot Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed physiclan and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical attending p for use as use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 \(\subset No. 2 No 1 Yes To the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: ٥ 1 Tes 2 **₩** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ck only within 2 29b. 29c. License number 29d. Date signed (Month, Day, Year) re and title of certifier 038675 13105 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an MESHULAM 301 ST PAUL PL #605 BAYMORE 21203 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 0 7 2005

		•	1 - State Registrar	State of Marylan	•	artment of F			giene	15 07110
	Physici		Decedent's Name (First, Middle, Last)	Betty Jane N	ichols	Knott		2. Date of Dea Month	ath	3. Time of Death 05 10:58 A M
	- /Medic Examin		4a. Facility Name (If not institution, give s Genesis Eldercar	street and number)		4b. City, Town, o	Location of Deal		4c. County of	
	Funeral Director		213 20 3003	7. Age (In yrs. 73	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		24,1931	9. Birthplace (State or Foreign Country) Maryland
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar		y, Town or Lo Balti					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28a Int be not	ai Director	10e. Street and Number 4200 Ritchie Hi	ghway		10f. Zip Code	21225		10g. Citizen of Wh	at Country?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Marical Exertine from the natified at	l by Funerai	11. Marital Status 1 Never Married 250 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 Yes 22 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. White
Maryland 21215-0036	d within 72 ho piene. r than "natur rhe Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 10th		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	prking	16b. Kind of Busi	ness/Industry
land ?	uld be filed Mental Hyg rked othe rtic event,	To Be C	17. Father's Name (First, Middle, Last) Elmer Ta	ılbott			18. Mother's Na	me (First, Middle, ary	Maiden Sumame)	
	is 1 and 2 sho of Health and N item 27 is ma other trauma	•	19a. Informant's Name/Relationship (Ty) George Knott Sr.	/ Husband	4200	Ritchie 1		Baltim	or, City or Town, St Ore, Mary	rate, Zip Code) rland 21225
Baltimore,	Page nent c ant: if ury or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	temoval from State	emetery, crer pudon F	sition (Name of matory or other place) Park Cem.	3/7	Date /2005		re, Maryland
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service License	ronuoud	40	01 Ritch	ie Highw	ay Balt	imore, Ma	rice, P.A. aryland 21225
	Physician		23a. Pafv. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the deather cause on each line.						Approximate Interval Between Onset and Death
Ì	/Medical Examiner	J.	Sequentially list conditions	Due to (or as a conseq						
8760, 1	cate be executed physician and the burial-transit	dicai Examiner	if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
.O. Box 68	The taw requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date Month	
<u>α</u>	w requires that is been signed by should be deta	by	Part II. Other significant conditions con	ntributing to death but not res	/ -/		en in Part I.			ute to the cause of death?
Vital Records,		Completed							rmed? prid	ore autopsy findings available or to completion of cause of ath? Yes 2 No
oţ	Attending Physician; Th r death. ect.cr. After this certificate by the funeral director, pag	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 16 27. Manner of Death 1 Ratural 5 Pending investigation	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	er: 4 Mursing I		ne) dence 6 ①Other now injury occurred	
Division	or At fter o lirec n by	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)		eet, factory, office		281. Location (S City or Ton		or Rural Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examination)	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death occ	urred at the time,	date and place, an	d due to the cause(s)
)	with Volume	Σ	30. Name and address of person who co	a mo.		29c. Licens	e number 55506		29d. Date signed (Month, Day, Year) 4/2005
	10 ,		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type.	Print)	Mar.	x 170	12/0-19	1 21225
	Sta Regist	ite rar	31. Date filed (Month, Day, Year) MAR 0 7	2005 Register's Signa	ture J.	Sparke				

			For State	State of Maryland	d / Dep	artment of H	Health and M	•	-	
_			Registrar		Ce	rtificate of	Death		Reg. No.	10 1/113
	Physici		1. Decedent's Name (First, Middle, La	LEVY				2. Date of De Month	_	3. Time of Death 12-15PM
j	/Medic Examir		4a. Facility Name (If not institution, give	ve street and number)		4b. City. Town, o	or Location of Death		4c. County	
	Lxaiiii			IDIAN NURSING H	IOME		LUTHER			BALTIMORE
	Funeral		5. Social Security Number 6. 5	Sex 7. Age (In yrs. I	ast birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th (V Year)	Birthplace (State or Foreign Country)
	Director			1□M 2NF 9(Yrs.	Months Days	Tiodis Will.	8. Date of Bir (Month, Da AUG. 24	,1914	MD
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or L	ocation				10d. Inside City Limits
	Mary -1 sh	ğ	MD BALT	IMORE	OWI	NGS MILLS	S			1 ☐ Yes 2 ☑ No
	h the	rec	10e. Street and Number			10f. Zip Code	<u> </u>		10g. Citizen of W	/hal Country?
	72 hours after death with the Maryland natural', or Items 23e or 28e-1 show dical Examinar must be notitled at	Funeral Director	4730 ATRIUM CO	URT #372			21117			USA
	r dea	Iner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Race	e - American Indian, k, White, etc.
36	s afte , or it	F.	1 Never Married 2 Married 3 1 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	,	Specify	
21215-0036	tural	Completed by	15. Decedent's E	Year or Dates:		dent's Usual Occup	astion		16b. Kind of Bu	
215	nin 72 n n Madis	plet	(Specify only highest gr	ade completed)	(Give	kind of work done DO NOT use retired	during most of work	ring	TOD. KING OF BU	sinessindustry
21	d within glene. er than "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	SEC	RETARY			CHIZUK	AMUNO CONG.
	be filed tal Hygi d other	Be (17. Father's Name (First, Middle, Last	")			18. Mother's Nam	e (First, Middle	Maiden Sumam	9)
yla	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, the Me	٥	ABRAHAM		CHE	NKIN	SOPHI	4		ROSINSKY
Maryland	permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23e or 28e-1 show any injury or other traumatic event, the Madical Examinar must be notified at ances.		19a. Informant's Name/Relationship	, , ,			and Number or Rui			
	1 and 2 Health em 27		HOWARD CHENKIN 20a. Method of Disposition			32 DUNBRI		- MUNIGI Date		LLAGE, MD 2088
ğ	Pages nent of I int: if it		1 X Burial 2 ☐ Cremation 3 ☐	☐Removal from State	metery, cre	matory or other plac	ce)			City or Town, State
Baltimore,	permit. Page Department (Important: If any injury or once.	1	 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice 		-	UNU AKLIN 2. Name and Addre	NGTON 3/4			MORE, MD
Ba	perm Depa Impo any i		RHALL	7			J.	DE FEAT	NSON & B	ROS., INC. LLE, MD 21208
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	oplications that caused the death	. Do not en	ter the mode of dying	ng, such as cardiac	or respiratory a	rrest,	Approximate
	Physician		Immediate Cause (Final							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequ		11 11/19	DIS EASI			(MONTA)
	Examiner		Sequentially list conditions	b						
	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due lo (or as a consequ	ence of):					
	be executed iclen and burlal-transit	хаш	that initiated events resulting in death) Last	c. Due to (or as a consequ	once of):					
760,	be ey	calE		Due to (or as a consequ	ence or,					
687	w requires that the death certificete be executed been signed by the attending physicien and should be detached for use as the burlat-transit		•	d						
Box (n certi	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23d. Date	of delivery
-	death e atte	Icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetaf 4 ☐ Pregnant at time of de		□Ectopic pregnancy □ Other (s <i>pecify)</i>	/ 		Mon	
P.0	at the by th	hys	9 Unknown	9□ Unknown						
	Physicien: The law requires that the death certifice this certificate has been signed by the attending phrail director, page 2 should be detached for use as the	Completed by Physician/Med	Part II. Other significant conditions		Iting in the u	nderlying cause giv	en in Part I.			bute to the cause of death?
oro	requi	ted	MACNUTRITI	(1)				101	/es 2⊠No	3 Probably 4 Unknown
Records,	elaw hasb	Jqr.						24a. Was autop	an 24b. W	ere autopsy findings available for to completion of cause of
<u>=</u>	n: Th icate r, pag								rmed? de 2⊡No 1	eath?
of Vital	ding Physicien: The lav h. Atter this certificate has funeral director, page 2:	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	26. Place of Deal			
ō	Phy or this oral d); To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	R/Outpatier 28b. Time o	II 3 DOA	4 Mursing Ho		dence 6 Othe	
ion	nding th. :: Afte	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury	Worl	k? Yes 2 □No			
Division	Atte	lifica	3 Suicide 6 Could not b	28e. Place of Injury - Al hor building, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (S	Street and Number	r or Rural Route Number,
Ö	itel or rs eft ai Dii	Certification;		building, etc. (Specify)				City or Tow	m, State)	
	To the Hospitel or Attending within 24 hours efter death. To the Funeral Director: Atter completely filled in by the funer	cal	29a. Certifier 1 Certifying Pl	nysician: To the best of my know miner: On the basis of examinati	rledge, deat	h occurred at the tin	ne, date and place,	and due to the	cause(s) and man	ner as stated,
	To tha h within 24 To the F complete	Medical		and manner stated.						
			29b. Signature and title of certifier			29c. Licens	_			(Month, Day, Year)
	(}	20 Name and address of pages in the	completed cause of death /h-	22a\ /T	Doint)	7945	1	MANCH	02 2005
	6		30. Name and address of person who	completed cause of death (Item		*	MIVE 70	ובינות	1100	712041
7	Sta	te	31. Dale filed (Month, Day, Year)	32. Registrar's Signatu	nte	4	1100	-07670	2017	(120.1
	Registr	ar	MAR 0 7	2005 Keene	1. A	pule				

			1 - For State Registrar		ryland / D		Health and M f Death	lental Hygi	•	07414
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last) WALTER B. LEWIS JR. 4a. Facility Name (If not institution, give s	•		4b. City, Town	, or Location of Death	2. Date of Death Month FEBRUARY	Z 26, 2005 4c. County of Death	3. Time of Death 11:00pM
	Funeral Director		210 00 9700	7. Age	(In yrs. last bint	BALTIMOnday) If Under 1 Year Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day, APRIL 24	N/A Year) 9. Birth Co. 1950 MAR	
	72 hours after death with the Maryland Instural; or iteme 23a or 28a-f show dical Examiner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County MD N/2 10e. Street and Number	A	10c. City, Town	RE				10d. Inside City Limits 1 May Yes 2 □ No
	eath with	erai Dir	1420 MAY COURT	10 Was Davidson	in the C	10f. Zip Code 21231			g. Citizen of What Cou	
9000	s within 72 hours after death with jiene. rithen "naturel", or iteme 23e or then "naturel" or iteme 23e or the Medical Examiner must be	d by Funeral	11. Marital Status 12 Never Married 2	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ XN If Yes, Give Year or Dates:		If Yes, specify Co	f Hispanic Origin? (Sp. uban, Mexican, Puerto lo Specify:	ecity Yes of No- Rican, etc.)	14. Race - Amer Black, White Specify: BL	ncan Indian, , etc. ACK
21215-0036	d within giene. ir then "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 10th		-	life. DO NOT use reti	ne during most of work	ing	6b. Kind of Business/li	ndustry 'E UNIVERSIT
Maryland	should be filed nd Mental Hygie marked other umatic event, II	36	17. Father's Name (First, Middle, Last) WALTER B. LEWIS SR	1			18. Mother's Name	TURNER		
	ges 1 and 2 should tof Health and Mer if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type EVONE A. BONNER (S)		100	7 E. BIDDI	LE STREET E	BALTIMORE	City or Town, State, Zi MARYLAND	21202
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ott		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □R. '4 □ Donation 5 □ Other (Specify) 21 January of Funeral Service License	//	cemetery		MARCH	9, 2005 VIN B. S	CRUGGS FUN	, MARYLAND
760,	ate be executed //Medical Examiner and interpretation and interpretations in the buriar-transit interpretation and interpretati	lical Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last	Due to (or as a		es me		or respiratory arres	st,	Approximate Interval Batween Onset and Death
.O. Box 68	at the death certificate be ex by the attending physicien tached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			23d. Date of deliv Month	very Day Year
s, P	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant conditions con	itributing to death bu	t not resulting in	the underlying cause	given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
al Record		Completed						24a. Was an autopsy performe 1 Yes 2	prior to co	opsy findings available ompletion of cause of
of Vital	di S	To Be	1 195 210,100	ospital:		Dationt 30 DOA	Other: 4 - Nursing Ho.		ce 6 ☐Other (Speci	(y)
Division	Attending death, inctor: After y the funer	ertification;	27. Manner of Seath 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injun (Month, Day) 28e. Place of Inju	Year) In	jury W	lork? □Yes 2□No	28d. Tescribe how 28f. Location (Stre	et and Number or Run	al Route Number,
Ö	To the Hospital or within 24 hours after To the Funeral Directory completely filled in b	O	29a. Certifier 1 Certifying Phys	building, etc	f my knowledge.	death occurred at the	time, date and place,	City or Town, and due to the cau	ISB(S) and manner as o	stated.
	To the Hi within 24 To the Fi complete	Medical	one)	and manner sta	led.				e and place, and due t	
•			30. Name an a of per in who control of the state of the s	WSO,	mo	00	006171	3	03.04.	-07
	7		30. Name an a of per in who con	Pr CAR	eath (Item 23a) (1	ype, Print)	SICN ST. C	3ATTMERE	5MD 2-12	15
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 7 2005	Registra	rs Signature	Gode				

				For State Registrar	State of Ma	arylar			of Health a	ind M		giene Reg. No.	005	07415
				Decedent's Name (First, Middle, Last)							2. Date of De		Year	3. Time of Death
		Physici /Medio			Samuel	S.	Morris						3, 2005	2:55 A M
		Examin		4a. Fecility Name (If not institution, give stre	et and number)			4b. City, Tox	wn, or Location o	f Death		4c. Co	unty of Death	
				Gilchrist Center					owson	14 Ura			Baltimo	
		Funeral Director		5. Social Security Number 6. Sex	2 F 7. Ag	e (in yrs. 75	last birthday) Yrs.	If Under 1 Y Months D	ear If Under 2 ays Hours	Min.	8. Date of Bir (Month, Da	y, Year)		place (State or Foreign htry)
		_		Usual Residence of Decedent							Dec. 2	7,1929	Virg	inia
		show		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
)		e Ma	cto	Maryland Balt	imore						D	undall	ζ.	1 ☐ Yes 2 🖾 No
Ain		or 28	Director	10e. Street and Number				10f. Zip Co				10g. Citizer	of What Cour	ntry?
		ath w	rai	2618 West Woodwe					212				ited St	
5		er de Item	Funeral		Was Decedent I		.S. 13. V	Vas Deceden Yes, specify	t of Hispanic Orig Cuban, Mexican	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)	14.	Race - Americ Black, White,	
13	36	urs aff	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	NO	1	☐ Yes 21X	No Specify:			Sp	ecity: Whi	.te
4	5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ther than Medical Exteriting remail by modified at	Completed by	15. Decedent's Educat	ion		16a. Deced	ent's Usual C	ccupation			16b. Kind	of Business/Inc	dustry
6	21	within 7 iene. than "r	npie	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5	5+)	lite. E	OO NOT use r	done during most retired)	or workii	ng			
10	21	e filed wi Il Hygien other th	Co	8 Years			L	abor					ntainer	Co.
105	aryland	be fill bd otl even	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle		<i>m</i> am <i>e)</i> ginia M	lorris
23	Ž	2 should be f and Mental H is marked of reumetic ever	ဥ	Raymond Morris 19a. Informant's Name/Relationship (Type	Print)		19h Mailin	a Address (S	treet and Numbe	r or Pura			-	
1	Ma	id 2 s ith an 27 is treui		Mr. Gregory Morr		n	261	8 West	Woodwe]	ll Ro	ad Du	indalk	, Maryl	and 21222
(i)	ē,	s 1 and 2 should be filed f Heelth and Mental Hyg Item 27 is marked othe other treumetic event,		20a. Method of Disposition		20b. F	Place of Dispos	sition (Name	of	D	ate	20c. Locat	ion - City or To	own, State
3	altimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren '4 ☐ Donation 5 ☐ Other (Specify)	noval from State		cemetery, crem ollv Hi		. Gdns.	3/3	3/2005	Mid	dle Riv	er, MD
*DIOK	att	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Service Licensee	- ~		1 22	Name and A	Address of Facility	y				
Q.	<u> </u>	88 2 8 8		Stephane	ella	22	290 1	u Ru 7922 W	ick Fune: ise Ave.	ral : Du	Home of	E Dund Marvl	alk, Ir	nc. 1222
3				23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused cause on each lin	I the deal								Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	and a	SMC	e Ch	mic c	063 Mort	rive	Polone	nousy d	iscary	Onset and Death
,		/Medical Examiner		resulting in death)	Due to (or as						7			1
×			io.	Sequentially list conditions. b.	Due to (or as	a consuc	иноси об:							
ζ.	/i	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	220 10 (0. 30		,401.00 01).							
3	,	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consec	(uence of):							
1 K	876	cate be executed ohysician and the burial-transit	dicai	d.							··· <u> </u>			
1		artifica ing ph e as ti	Med	IF FEMALE:										
	Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome 1□Live birth	2 Feta	al death 3	Ectopic pregr				23d	. Date of delive Month	Pry Day Year
C	0.	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of o	leath 5□	Other (special	fy)				WONE	Day
0	٥.	that the od by detact	/ Ph	Part II. Other significant conditions contri	buting to death b	ut not res	ulting in the ur	iderlying caus	se given in Part I.		23e. Did 1	obacco use	contribute to th	ne cause of death?
G	ds	puires n sign ald be	d by								1 0	Yes 2 N	lo 3 Prob	ably 4 Unknown
	00	s been	oiete								24a. Was	an 2	4b. Were auto	psy findings available
	of Vital Record	The late ha	Completed								auto perfo	psy ormed? 2 No	prior to cor death? 1 ☐ Yes	mpletion of cause of
	ta	intifica	BeC	25. Was case referred to medical					26. Place	of Death	Check on		1 🗆 165	2 100
	<u></u>	hysic his ce I direc	To	examiner? 1 ☐ Yes 2 ☑ No Hos	pital: 1 🗌 Inpatie	ent 2	ER/Outpatien	d 3□ DOA	Other: 4 ☐ Nui	rsing Hor	ne 5□Resi	dence 6	Other (Special	nospice
	n	ing P	on:	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury		Injury at Work?		28d. Describe	how injury o	ccurred	
	isio	ttend death stor: /	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	00 - Diana of lai	At b	oma farm str	M	1 □ Yes 2 □ N	-	194 Location /	Ctront and t	(mbaras D. m	/ On the March and
	Division	tel or Attendis s after death. el Director: A ed in by the fu	ertification:	4 Homicide determined	28e. Place of Injudence building, et	ury - At n c. <i>(Speci</i>	fy)	et, factory, o	TICE	4	City or To	street and N wn, State)	umber or Hura	l Route Number,
		To the Hospitel or Attending Physicien: The law requires that the death certifur within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	O	29a. Certifier Gertifying Physic	ian: To the best	of my kno	owledge, death	occurred at t	he time, date and	d place, a	and due to the	cause(s) an	d manner as st	tated.
		he Ho in 24 I he Fu pletely	edical	(Check only 2 Medical Examine one)	r: On the basis of and manner sta	f examina ated.	ation and/or inv	estigation, in	my opinion, deat	th occurre	ed at the time,	date and pla	ace, and due to	the cause(s)
		To t To t	Σ	29b. Signature and title of certifier	9	_		57	icense number	2		_	igned (Month.	
	•			year	V W	()		4	128 ×)>		Schol	eary	NS 1002
	/	16.61		30. Name and address of person who com	pleted cause of d	leath (Ite	n 23a) (Type, I	Print)	Charle.	8	5 Bul	Frem	- cus	21204
	/	Sta	ate	(1 0 0 0 0					00-0	4				
		Regist		31. Date filed (Month, Day, Year) MAR 0 7 2005	3 Registr	1	1 Age	2						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

					Marylariu	Cei	rtificate of	health ai <i>Death</i>	nd Mental H	ygiene Reg. No	05	07416
	Physi	cian	1. Decedent's Name (First, Middle	•					2. Date of D		Y-III	3. Time of Death
1	/Med Exam		Allan Winfiel 4a. Facility Name (If not institution						March	6, 2 <u>0</u> 09		5:45 AM
1			Pickersgill F	Retirement	Communi	ty		4b. City, Towr Toய	n, or Location of Dea SON	th 4c. Cou	nty of Death Balti	
	Funera Directo		5. Social Security Number 215–10–9628 Usual Residence of Decedent	6. Sex 7 1⊠ M 2□ F	'. Age (In yrs. last 99	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of B Min. (Month, D August 1	irth Pay, Year) 11. 1905	9. Birthp	lace (State or Foreign try) 12nd
	yland		10a. State 10b. County		10c. City, To	own or Lo	cation					
	e Mar	ģ	Maryland Balti	.more		JSON					10	0d. Inside City Limits 1 ☐ Yes 2 No
	ith th or 28	Ji e	10e. Street end Number				10f. Zip Code			10g. Citizen o	of What Count	
	ath w	rai	615 Chestnut Av	enue			21204			3. 5.1.20.1.0	USA	iry r
020	filed within 72 hours efter death with the Maryland Hygiane. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Force	i⊠ No		Vas Decedent of H Yes, specify Cuba □ Yes 2 X No	ispanic Origin In, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	0- 14. R B	ace - America lack, White, e	
5-0	72 ho	ted	15. Decedent's	s Education		a. Decede	ent's Usual Occum	ation				
Maryland 21215-0020	filed within Hygiane. ther than "r nt, the Mad	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4			ent's Usual Occup kind of work done o O NOT use retired		working		Business/Indi	
nd	al Hy fothe	Bec	17. Father's Name (First, Middle, L			<u> </u>			Name (First, Middle	Dredge	venutact	turing
₹	Mant Mant arked	Į.	Charles Mur					Loui		lbrecht		
Mai	12sh hand rism traum		19a. Informant's Name/Relationshi		15	b. Mailing	Address (Street a	and Number o	r Rural Route Numb			Code)
<u>ရ</u>	Healt Healt Her		Mr. Brian R. Mur	nd (Son)	10	O Bor	nnie Hill	L Road	Towson,	Marylar	nd 2120	3 4
ē	beges ent of it: If it y or c		1X Burial 2 ☐ Cremation 3	3 Removal from Sta	cemet	ery, crema	ition (Name of atory or other place	e)	Date	20c. Location		n, State
Baltimore,	permit. Peges 1 and 2 should be filed w Department of Health and Mantal Hygias Important: If Item 27 is marked other ti any injury or other traumatic event, in once.		4 Donation 5 Other (Spe 21. Signature of Funeral Service Li				Cemetery Name and Addres	a - 4 15 - 115	3/8/2005	Baltim	ore M	laryland
ñ	Depa impo any ir		Michael	Auch.	m	Ruc	k Towson Fi	neral H	bme, Inc. 1	050 Yark	Road To	21204 wson, Md.
	Physician	2 1/1	23a. Part 1. Enter the disease of conshock, or heart failure. List or	omplications that cause ily one cause on each	sed the death. Do	not enter	the mode of dying	, such as card	diac or respiratory ar	rest,		pproximate
	/Medical		Immediate Cause (Final	<u> </u>	1 (1		Da		4		Ö	Inset and Death
	Examiner		disease or condition resulting in death)	e	0 37	Mge		nenti.	A			years)
	D #	Iner			Due to (or es a	conseque	ence of):				U	
5	ificeta be executed 3 physician and as the bunal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executed.	b	Due to (or es a	conseque	ence of):				İ	
,00100	riceta be	Medical	Cause (Disease or injury thet initiated events resulting in death) Last	c	Due to (or as a	conseque	nce of):					
Y	th certi			d								
5	tha att	Physician/	Part II. Other algnificant conditions	contributing to death	but not resulting i	n the unde	erlying cause giver	in Part I	20h Dida	Will House		
•	as mar m ignad by be datac	by Ph							1□ Y			e cauae of death?
to the road and a	within 24 hours after death. To the Funarel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Completed							24a. Was a perfori	n autopsy med?	availa	autopsy findings ble prior to letion of cause th?
	ifficati		25. Was case referred to medical						1 □ Ye	es 2 No	1 🗆 Y	es 2□ No
. icias	s cert direct	0	exeminer?	Hospital:	i 0 [50/0		Othor		eath (Check only on			
d or	ter thi	Ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D		ime of	28c. Injury a	4 Nursing	Home 5 Reside			
andi	eath.	catic	2 Accident investigation	on	ay rear)	njury	Work? M 1 ☐ Ye	s 2 No		an injury coodin	00	
tal or At	irs aftar of all Direct lad in by	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	d 28e. Place of In	ijury - At home, fa tc. (Specify)	rm, street,	factory, office		28f. Location (St. City or Town	reet and Number, State)	er or Rurel Ro	oute Number,
he Hosp	in 24 hou he Funai pietaly fiil	6 000	29a. Certifier (Check only one) 1 Certifying Pl	hysician: To the best miner: On the basis of and manner st	of my knowledge, of examination and tated.	, death oc d/or invest	curred at the time, igation, in my opin	date and place ion, death occ	e, and due to the ce urred at the time, da	use(s) and ma	nner as stated	d. cause(s)
Tot	To t	Σ	29b. Signature and title of partifier	1	1:0		29c License n	umbor				
	10	3	0. Name and address of person who	completed cause of	death (Kem 23a) (Type, Prin	1).40		1	MAVE	47,0	2005
			1. Date filed (Marth Day Year) 7	24	SIMC	6	OI N	- Cha	rles St.	Baly	+ Md	<1.50x
	State Registra		Sale med (MINTERS) refr) 20	U3 Bagist	ar's Signature	1000						

		•	For State Registrar	State of Marylar		artment of H			giene	5 07117
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	TERESA V.	MAROU	SEK		2. Date of Dea Month MARCH	ath _	3. Time of Death / 11:35 р. м
	Examin		4a. Facility Name (If not institution, give : GOOD SAMARITAN NUI				TIMORE		4c. County of I	Death
	Funeral Director		5. Social Security Number 220-05-5198 6. Sep Usual Residence of Decedent	7. Age (In yrs. 86	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da 04-09-	y, Year) -1918	Birthplace (State or Foreign Country) MARYLAND
	Maryland -f show lied al	tor	10a. State 10b. County	NNE'S	ity, Town or Lo	STEVENSV	'ILLE			10d. Inside City Limits 1 ☐ Yes 2\(\timex\)\(\timex\)\(\timex\)\(\timex\)
	th with the 23a or 28e	al Direc	10e. Street and Number 160 NORTH LAKE	DRIVE		10f. Zip Code	21666		10g. Citizen of Wha	,
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, the Medical Examinat must be notified at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ★ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2/T/No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※XX No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	- 14. Race - Black, \ Specify:	American Indian, White, etc. WHITE
121215-0036	filed within 72 h Hygiene. other than "natuent, Ine Made	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 YEARS	cation a completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired HOUSEWIFE	during most of wor			ess/Industry
Maryland	should be fi and Mental H s marked ot umatic ever	To Be	17. Father's Name (First, Middle, Last) THOMAS		LENOVS		MARY	ELIZA		DHLMAN
	1 and 2 sho Health and em 27 is m		19a. Informant's Name/Relationship (Ty TERESA NEUBAUER	(DAUGHTER)	220	DUKE OF Y		,COCKEYS	SVILLE, MD	21030
Baltimore,	Pant and		20a. Method of Disposition XX Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)		aamataa, ara	osition (Name of matory or other play EDEEMER C	EM. 03-0	Date 5-2005	BALTIMORE	y or Town, State E, MARYLAND
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service License	R.G.RU		2. Name and Addre		L HOME,I	NC. TOWS	YORK ROAD SON,MD.21204
	Fri ysicia n /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the dea ne cause on each line. Due to (or as a conse	Vase	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
8760,	executed physician and physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the to (or as a consection).	quence of):	alle	ert.	peli	ue	bue year
.O. Box 6	The law requires that the death certifics to has been signed by the attending pt bage 2 should be detached for use as to	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes XX No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3[Ectopic pregnancy	/		23d. Date of Month	f delivery Day Year
Δ.	quires that in signed b uld be deta	ed by PI	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.			te to the cause of death?
al Records,		Completed							rmed? prior deat	e autopsy findings available to completion of cause of the cause of th
Division of Vital	Phys this al dii	atlon; To Be	25. Was case referred to medical examiner? 1 Yes	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	er: 4XXVursing H		nne dence 6 Other (now injury occurred	Specify)
Divis	al or Atte s after des il Directo od in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	reet, factory, office		28f. Location (S City or Tox		or Rural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical (29a. Certifier (Check only one) XX Certifying Physical Cartifying	sician: To the best of my kn ner: On the basis of examinated and manner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occu	, and due to the orred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
)	To the within To the comp	$\mathbf{\Sigma}$	29b. Signature and title of certifier &	Tupee	ami	29c. Licens	30661		29d. Date signed (A MARCH 4	fonth, Day, Year)
	0)		30. Name and address of person who co			PrintBalli	enore .	Hd-	212-39	? .
	Sta Registr		31. Date filed Warth Day, Year, 2005	32. Registrar's Sign	ature					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Vaar **Physician** iol 11:30 PM 2005 March /Medical . Facility Name (If not institution 4b. City, Town, or Location of Death give street and number) 4c. County of Death **Examiner** Maryland Medical Center (Iniversit If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Year) 1**X**M 2□ F 212-46-7979 65 Italy Director thoust 3, Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or Itams 23a or 28a-1 show wher court be notified at MD n/a 1X Yes 2 □ No Baltimore Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21224 3423 Ε. Pratt Street USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: The Madical Exp. ≥ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Whittman Requardt College (1-4or 5+) 5 + marked other than Elementary/Secondary (0-12) Engineer & Assoc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be filk tment of Health and Mental Hi tant: If item 27 Is marked of Be Gelsomina Rossi Thomas Muti 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Giuseppina Muti 3423 E. Pratt St., Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or injury or 3/9/2005 Baltimore, MD Oaklawn * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility $Joseph\ N$. 21. Signature of Funeral Service Licensee Jr. FH Md.21224 Zannino Marea H. Zannung

23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 263 S. Conkling St. Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** One week /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a Wasan certificate has autopsy performe 1 Yes 2 1 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After or Attending 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗍 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) Portland 5+ Bultimore Maryland 32. Registrar's Signature 31. Date filed State Registrar

			e Type or Pri n State of Ma			e Ink. Ensuint of Health a				
		1 - For State Registrar				e of Death		Reg. No.	211115	07420
	sician edical	1. Decedent's Name (First, Middle, Dorothy Ann Ph					2. Date of D Month Marc	, Day	y Year	3. Time of Death
ž.	niner	4a. Facility Name (If not institution,		(G.F.)	4b. City,	Town, or Location of		1	County of Death	0 1.25
Fune	al		. Sex 7. Age	SpiTal			4 Hfs. 8. Date of B	irth	N/A 9. Birthpl	ace (State or Foreign
Direct	or	215-30-4635 Usual Residence of Decedent	1□ M 2 F	73 Yrs	Months	Days Hours	Min. (Month, D Jan. 23	3, 193	Count	try)
larylan show	2	10a. State 10b. County		10c. City, Town o					10	Od. Inside City Limits
r 28e-f	recto	MD N/A		Balti	more 10f. Zip	Code		10g Citi	izen of What Count	1 Yes 2 No
ath with	raiD	1643 Heathfield	Road			21239		U	.S.A.	.,,
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if the fath and Mental Hygiene. If the 27 Is marked other then "naturel", or items 23e or 28e-f show other treumatic event, the Medical Example Francis the notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1	Ever in U.S.	3. Was Deced If Yes, spec	dent of Hispanic Origicify Cuban, Mexican, 2 XNo Specify:	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - America Black, White, e Specify: Whi	etc.
15-0 n 72 hc	leted	15. Decedent's (Specify only highest of	Education grade completed)	16a. De	ive kind of wo	al Occupation rk done during most of se retired)	of working	16b. Ki	nd of Business/Inde	ustry
d 21215-0036 filed within 72 hours aff Hygiene. ther then "naturel", or ont, the Medical Evarid	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	. Cashi			Good	d Samarit	an Hospita
yland 2 build be filled Mental Hygid arked other attic event,	Be	17. Father's Name (First, Middle, La	•	· · · · · · · · · · · · · · · · · · ·		1	s Name (First, Middle	, Maiden	Sumame)	
Maryland d 2 should be file th and Mental Hy 7 is marked oth treumatic event	2	Charles W. Ew		19b. M	ailing Address	Mary (Street and Number	/ E. Stras			Codel
e, Ma 1 and 2 : Health ar em 27 is		Jane Phillips -				idge Road				
Baltimore, Dermit. Pages 1 ar Department of Hea Importent: If item; any injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State		rematory or or	ther place)	Date /7 /05		cation - City or Tow	
Baltimor permit. Pages Department of P Importent: If ite any injury or of	9	* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice				ce Corp. 3			on, Maryl	Lanu
0 48 4	ouce	Peath	La Can		5305 H	Harford Ro	ad Baltimo	ore,	•	21214
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68760, Rificate be executed g physician and as the burial-transit	dicai Examiner		c	consequence of):						
death certif de ettending d for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetel death	3 □Ectopic pre 5 □ Other (spe			2	3d. Date of delivery Month D	y Day Year
£ 50 8	by	Part II. Other significant conditions	contributing to death but	t not resulting in the	underlying ca	ause given in Part I.	200		se contribute to the	cause of death?
The The page	e Completed	OF Weep and the state of the st					1 Tes	osy ormed? 2 3-No	24b. Were autops prior to comp death? 1 \(\text{Yes} \) 2	sy findings available pletion of cause of
of Vital Physicien: this certifica	OB	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	t 2 ER/Outpat	ient 3 DO	Othor	Death (Check only only only only only only only only		T015 /0 /1	
E g je je	lon: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	28b. Time	of 28	Bc. Injury at Work?	28d. Describe			
S ten ten tor	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be One Diese of leive	y - At home, farm, (Specify)	street, factory,	1 Yes 2 No		Street and wn, State)	Number or Rural F	Route Number.
DIVI To the Hospitel or Al within 24 hours after or To the Funerel Direc	edical	29a. Certifier (Check only one)	Physicien: To the best of eminer: On the basis of eminer state	examination and/or	ath occurred a investigation,	at the time, date and p in my opinion, death	place, and due to the occurred at the time,	cause(s) a date and p	and manner as stat place, and due to the	ed. he cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	0.10			License number			signed (Month, Da	ly, Year)
()		30. Name and address of person w	o completed cause of do-	ath (Item 23a) (Tue		5546		worch	5,2005	
8		CHOOSES COUNTY	completed cause of dea	ode Kave	en Blue	, Baltin	con son	203	7	
Regi	State strar	31. Date filed MAR Dy. 20	32. Registrar	's Signature	10	,				

Dorothy Phillips

		^	For State Registrar	State o	f Marylar		artment <i>tificate</i>			ind M	lental Hy	ygien Reg. N	2110	0742
ř	Physici /Medic Examir	al	Decedent's Name (First, Middle	NNIE		NE!	4b. City, T	own, or L	ocation o	f Death	2. Date of D Month MARC	4	ay Yeer 2 200 c. County of Dea	3. Time of Death 5413 M th Am
*	Funeral Director		NO12 TH WES 7 5. Social Security Number 225-58-3464	HOSPITA 6. Sex 1 M 2□ F	7. Age (In yrs. 5)		ff Under 1 Months		Hours	24 Hrs. Min.	8. Date of Bi (Month, D June	irth ay Yea 20 •	1948 Ma	uOn = thptace (State or Foreign ountry) ry Land
	hours after death with the Maryland tural; or Items 23a or 28a-f show al Ezar it art frust be a willfied at	Director	Usuaf Residence of Decedent 10a. State 10b. County MD 10e. Street and Number			y, Town or Lo		`ada				100.0	itizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ar death with the Marylan tems 23a or 28a-f show	nerai Dir	2625 Rosewood	12 Was Dece	edent Ever in U	.S. 13.		2121		gin? (Spe	ecify Yes or N Rican, etc.)		USA 14. Race - Ame Black, Whit	erican Indian,
2-0036	within 72 hours after dea one: than "natural", or Items on Medical Exart in or Ite	ed by Funeral	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Moivorced		/ 0	16a, Decer	1 □ Yes 2	X No Occupati	Specify:				Consider	lack
1212	filed within 72 Hygiene. other than "nai ant, I've Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	(Give	kind of work DO NOT use abled	done dui retired)	ring most		ng (First, Middle	N	lone	
aryland	should be nd Mental markad o	To Be	17. Father's Name (First, Middle, Thomas Powe11 19a. Informant's Name/Relations	hip (Type, Print)				Street an	C1a	audi. or or Rura	a Blow	ber, City	or Town, State, a	Zip Code)
iore, ma	Pages 1 and 2: nent of Heatth ar int: If itam 27 is iry or othar trau		Laura Johnson 20a. Method of Disposition 1 Burial 2 □ Cremation		20b. F	Place of Dispo cemetery, crer	sition (Name	of er place)		D	anklin	20c.	Location - City or	
Baitimore	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service			elping I	Name and	Address Fun	of Facility eral	3-9- Hom Stre	e	-	and, VA	, Virginia 23837
	Physician /Medical		23a Part1. Enter the disease, or shoc or heart failure. List Immediat Cause (Final disease or condition resulting in death)	a	saused the deat each line. SEP (or as a consec	515	er the mode	of dying,	such as o	cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death
9/60,	Examiner be executed by sician and burial-transit sihe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	(or as a consequence of consequence)	Si Diluence of):		Pi	VEL	ince	2274			
O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	tcome of pregna birth 2 Feta nant at time of cown	Ideath 3	Ectopic pred Other (spec						23d. Date of del Month	livery Day Year
ords, P.	w requires that is been signed by should be deta	þ		VEMIA	eath but not res	sulting in the u	nderlying cau	ise given	in Part I.	,		Yes 2		the cause of death?
Vital Records		Completed	HypoTue		; R	ESPI	RATO	/	TAZ	lein	1 Yes	opsy ormed?	prior to death?	utopsy findings available completion of cause of
ō	ling Phy 1. After this uneral d	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 16 27. Manner of Death 1 Matural 5 Pendir 2 Accident investi	Hospital: 1 28a. Date (Monggation		ER/Outpatier 28b. Time of Injury		Other: c. Injury a Work?	4 □ Nur	rsing Hon	(Check only ne 5 ☐ Res 28d. Describe	idence	6 Other (Speury occurred	cify)
Division	pital or Atteno	i Certification;	3 Suicide 6 Could determ	nined 289. Place build	of Injury - At h	(y)			dete and		City or To	wn, Sta	te)	ural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	Medical					vestigation, ii	n my opir License r	nion, deat	h occurre	ad at the time.	, date ar 29d. D	ate signed (Mont	to the cause(s)
			1 (18	ests	ms)19	50:	2		MA	2CH 2	2005
	Sta Registi		30. Name and address of person OR / He Jay 31. Date filed (Month, Day, Year)	B. CONA	se of death (Iter	MD	erint)	RA.	W/4.	487	EST O	185	DITAL MANYC	AND 2/13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 12332 PM **Physician** cone MARCH 2005 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 7. Age (In yrs. last birthday) XX 8. Date of Birth (Month, Day, Year) 3 - 10 - 45 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours MHK Director Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County ral', or items 23a or 28e-f show Examinations! be notified at 1 ☐ Yes 2 No Directo ALT MORE TIMORE 10f. Zip Code 10g, Citizen of What Country? 1234 \bigcirc Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married , 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 Divorced Year or Dates: "natural" 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) i and Mental Hygiene. Is marked other than a Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be U 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important; if item 27 is
any injury or other trac HIXOR 20b. Place of Disposition (Name of cemetery, crematory or other place) . Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 Donation YORKRD TIMON 21. Signature of Funeral Service Licenses AUCOLA MEACEFUL ALTERNATIVE 23a. Part1. Enter the disease, or omplications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate / /2 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COAGYLO PATH 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? CIRRHOSIS 24a. Was an autopsy 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Minpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide within 24 hours a To the Funeral I lilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

PULIFRONE

POSEPH

State Registrar 31. Date filed (Month, Day, MAR

29b. Signature and title of certifier

RAVEN BLVD BALTIMORE 32 Registrar's Signative

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAM [ON

29c. License number

RES

000

29d. Date signed (Month, Day, Year)

OLIVIER

MARCH, 04, 2005

	1 - For State Registrar	State of Maryla	•	artment of H rtificate of I			Jiene leg. No.		
	1. Decedent's Name (First, Middle	, Last)				2. Date of Dea	th 21	105	3. Time of Deatl
Physician /Medical	Mary E	lizabeth Pitarr	ca				4, 20		9:36AM
Examiner	4a. Facility Name (If not institution	, give street and number)		4b. City, Town, or		ath	4c. County	of Death	
		oland Park		Bal If Under 1 Year	timore	50 lo D : (B):			
Funeral Director	5. Social Security Number	4 DM WITE	s. last birthday) 1 Yrs.	Months Days	Hours Mi		, Year)	9. Birthplac	
	220-14-9847 Usual Residence of Decedent		/1		l	Jan. 0,	1914		MD
E Po	10a. State 10b. County	10c. C	city, Town or L	ocation				100	f. Inside City Lin
tified at	MD		Baltim	ore					1 X Yes 2 □
be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country	y?
s 23a	3019 Glen Ave			212			1	USA	
Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23s or 28s-f show important: If itam 27 is marked other than "natural", or other traumatic event, the Medical Examiner in ust be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 □ Yes 2 ☒No if Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	Specify:	- American	C.
atura ed t	15. Decedent		16a, Dece	dent's Usual Occup	ation		16b. Kind of Bu		nite
ygiene. Nor than "natura It, the Madical I Completed	(Specify only highest Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	durina most of w	vorking	TOD. THING OF BU	5111030a 17100	3.i.y
giene tha the	10	College (1-401 5+)	Sa1	es			Retail I	Dept.	Store
d other avant,	17. Father's Name (First, Middle,	Last)			18. Mother's N	ame (First, Middle,	Maiden Sumame	9)	-
Menta arked atic e	Henry Rinehart				Eli	zabeth Ca	11ahan		
and is me	19a. Informant's Name/Relations	nip (Type, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Numbe	r, City or Town,	State, Zip C	ode)
ealth m 27 ner tr	Salvatore W. Pi		3019	Glen Ave	., Balt	imore, MD			
f ita	20a. Method of Disposition 11 Burial 2 Cremation		cemetery, cre	osition (Name of matory or other plac	e)	Date	20c. Location - (City or Town	n, State
tment: jury	`4 Donation 5 ☐ Other (Si			dge Cemet		8/05	Pikesvil	le, N	TD C
Depar impor any in once.	21. Signature of Funeral Service	Licensee		2. Name and Addres			24 Reist		
J = 0 G	pher	complications that caused the dea		Eline Fun			sterstov	12.14.14	
	shock, or heart failure. List	only one cause on each line.	atti. Do flot en	ter the mode of dyin	g, such as card	ac or respiratory an	est,	lr.	opproximate Interval Betwee Onset and Deat
ysician ledical	disease or condition resulting in death)	-a Yrobr	Some	Deel	me				
aminer		Due to (or as a sinse	equence of):	O					
<u></u>	Sequentially list conditions, if any, leading to immediate cause. Error Uncertainty	b. Due to (or as a conse	equence of):	97	Series as				
in and ial-transit Examlner	Cause (Disease or injury that initiated events	Desg	ensa	true (Jam	+ DI	seance		
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physician and the burial-transit dical Examír		o why	ral	Vam	Kon	bosca	49		
ing pl e as t	IF FEMALE:								
gned by the attending to be detached for use as by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	tal death 3[Ectopic pregnancy			23d. Date Mon	of delivery	ay Year
the a	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)					-,
detar	Part II. Other significant condition	ons contributing to death but not re	sulting in the L	nderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to the	cause of death
	aleme	me	-			1□Y	es 2 No	3 🗌 Probab	oly 4 🖽 nkr
should should	And to	~				24a. Was a	24b W	lere autone	v findings avai
has le 2	10 7 00					- autop perfor	med? 🖊 💢	eath?	y findings avai pletion of cause —
certificate rector, pag	25. Was case referred to medical				26 Place of C	1 ☐ Yes eath (Check only of		☐ Yes 2l	∐ No
ω ≔ O	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	☐ ER/Outpatie	nt 3 DOA Oth		Home 5 Resid		r (Specify)	
	27. Manner of Death	28a. Date of Injury	28b. Time o		/ at		ow injury occurre		
to the fur	1 ☐Natural 5 ☐ Pendin 2 ☐ Accident investig	ation	Injury		Yes 2□No				
al Director: After ted in by the funeral	3 Suicide 6 Could (not be ined 28e. Place of Injury - At I building, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural F	Route Number,
ha Funer bletely filt edical	29a. Certifier 1 Certifyin (Check only 2 Medicel	g Physicien: To the best of my kr Exeminer: On the basis of examin and manner stated.	nowledge, deal nation and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the courred at the time, of	ause(s) and mar date and place, a	nner as state nd due to th	ed. ne cause(s)
To to to to to to to to to to to to to to	29b. Signature and title of certifie	(- &	1000	29c. License	number		29d. Date signed	(Month, Da	y, Year)
1) / JOHN	21	VV())	N N	717	7	3(4)	105	
5	30. Name and address of person SHOALIS A	who completed cause of death (Ite	23a) (Type,	N. Euto	w 81	Frute 3	108 B	alt.	mD2
State	31. Date filed (Month, Day, Year)	37 Registrar's Sign	nature						

		1	1 - For State Registrer	of Maryland / D	Department of H Certificate of L	Death	Reg. N	6005	07424
	Physicia	an	1. Decedent's Name (First, Middle, Last) Jessie Beatrice R	obinson			Date of Death Month D	ay Year 2005	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give street and	Roll wo	re Baltin	Location of Death		c. County of Death	no (State or Fernian
ı	Funeral Director		338-18-2666 ¹□M ஜ		Yrs. Months Days	Hours Min.	(Month. Dav. Year	908 Kent	ce (State or Foreign) ucky
	Maryland f show		Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. City, Town	Baltimore			100	I. Inside City Limits
	or 28a-	Directo	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Country	P
	eath w	Funeral (4715 Norwood Avenue	ecedent Ever in U.S.	13 Was Decedent of H	21207	Ves or No-	USA 14. Race - American	Indian
036	72 hours after death with the Maryland natural, or Itema 23a or 28a-1 show deat Examinar must be notified at	by	1 Never Married 2 Married 1 7	Forces? es 2 XNo Give or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	in, Mexican, Puerto Ric Specify:	an, etc.)	Black, White, etc. Specify: Black	D
21215-003	be filed within 72 hours after death with the Marylar tal Hygiene. d other than "natural", or Itema 23a or 28a-1 show event, the Mudical Examinat must be natified at	Completed		e (1-4or 5+)	Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired	during most of working f)		Kind of Business/Indu	
ر ام	e filed v Il Hygie other t vent, th	0	11th grade 17. Father's Name (First, Middle, Last)	HC	ousekeepin	.G 18. Mother's Name (F	irst, Middle, Maide	n Sumame)	
Maryland		ToB	Jesse Lander 19a. Informant's Name/Relationship (Type, Print)	100	. Mailing Address (Street	Frances		n n K	o do l
	nd 2 :		Wynonia M. Adams/Da		715 Norwoo		-		
altimore,	Pages 1 aument of Heanant: If item ury or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from 1 ☐ Donation 5 ☐ Other (Specify)	m State cemeter	Disposition (Name of ry, crematory or other place ant Rest C	emetery	Tov	Jocation - City or Town	yland
Balt	pernit. Pages Department of Important: If i any injury or once.		21. Signature of Euneral Service License			ss of Facility Cha sterstown			
	Pnysician		23a Party. Enter the disease, or complications the shock, or heart tallure. List only one cause of immediate Cause (Final disease or condition	at caused the death. Do not each line.	not enter the mode of dyin	g, such as cardiac or re	espiratory arrest,	Ir	pproximate hterval Between Onset and Death
	/Medical Examiner		resulting in death) Due Sequentially list conditions, b.	therosch	evotic Co	ardiova	scular	Disease	Yeavs
V	s be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	to (or as a consequence to (or as a consequence					
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.O. Box 6	ne death certif the attending thed for use a	Physician/Medical	23b. Was decedent pregnant 1 Linin the past 12 months?	outcome of pregnancy re birth 2 Testal death egnant at time of death nknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delivery Month D	ay Year
<u>α</u>	quires that the signed by all be detacted	þ	Part II. Other significant conditions contributing to Cevely at Few	o death but not resulting in	the underlying cause give		23e. Did tobacco	use contribute to the	
Records,	The law requir te has been si age 2 should	Completed		0		<u>()</u>	24a. Was an autopsy performed?	prior to comp death?	y findings available letion of cause of
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?		Oth	26. Place of Death (C	Check only one)		
	음 문 등	n: To	27. Manna 1 Death 28a. D		Itpatient 3 DOA Time of 28c. Injury Worl	vat 280	5 Residence I. Describe how inj	6 □Other (Specify) ury occurred	
Division of	ttendir death. ctor: Af / the fur	ertification;	2 Accident investigation 3 Suicide 6 Could not be	ace of Injury - At home, fa	M 1 🗆	Yes 2 □ No	Location (Street a	and Number or Rural F	Route Number.
<u>></u>	tal or A	Certil		uilding, etc. (Specify)			City or Town, Sta	te)	
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physician: To (Check on one) 2 Medical Exeminer: On the and r						
)	To th withir To th comp	Me	29b. Signature and title of certifier	٠	29c Licens	6 number 5 3 7 9	29d. D Fe k	ate signed (Month, Da	y, Year) , 2005
	3		Steven L-sotte M.D.	ause of death (Item 23a) 2401 West	(Type, Print) Silve Belveder	e live.	saltin	ove, Md	121215
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 7 2005	2. Prigistrar's Signature	Sido				,
DH	IMH 17 Rev 1/2	001		1000					

DHMH 17 Rev 1/2001

Robinson, Jessie

			1 - For State Registrar	State of Marylan	•	ent of Health and ate of Death	d Mental Hygie	4000	07425
	Dhusisi		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic	al		TKOWSKI			Maria	05 200:	
	Examin	er	1-1-1	OSPITAL		ty, Town, or Location of De BALTI MORA der 1 Year If Under 24 F	E		THORE
В	Funeral Director		5. Social Security Number 6. Sex 1 \(\overline{\pi} \)	7. Age (In yrs. 59	Yrs. Month		8. Date of Birth (Month Day, Ye April 24	,1945 Pen	hplace (State or Foreign untry) NSYlvania
	pu k		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	Maryla -f sho	to	MD N/A		altimore				1 ☐ Yes 2 ☐ No
	or 28a	Director	10e. Street and Number			Zip Code	10g.	Citizen of What Co	untry?
	ath wi	rai	837 W. 33rd Street			21211		U.S.A.	dana tadian
39	filed within 72 hours after death with the Maryland Hyglene. Kher than "natural", or Items 23a or 28a-f show ther than Medical Exarcia writher be inclified at	by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? pecify Cuban, Mexican, Pu 2 2 No Specify:	(Spectry Yes or No- Jerto Rican, etc.)	14. Race - Ame Black, White Specify: W	
2-0("natural", or		15. Decedent's Educa (Specify only highest grade		16a. Decedent's U (Give kind of	work done during most of t	working 16t	b. Kind of Business/	industry
121	be filed within 72 ho ital Hygiene. id other than "natur event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Sprir	ıkler Fitter		Local 536	5
Dd 2	2 should be filed within and Mental Hygiene. is marked other than sumatic event, the M	Be C	17. Father's Name (First, Middle, Last)		, , , , , , , , , , , , , , , , , , ,	18. Mother's h	Name (First, Middle, Mai	iden Sumame)	
<u>ya</u>	should b nd Ments marked	To	Ben Rutkowski				ell Frazie		
Maryland 21215-0036	2 2 2 2		19a. Informant's Name/Relationship (Typ. Mrs. Linda Rutkowsk		19b. Mailing Addr 837 W. 3	ess (Street and Number or Bard Street E	Rural Route Number, C. Baltimore, M	ity or Town, State, 2 1aryland 2	Zip Code) 21211
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke eny injury or other treumatic once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re	moval from State	Place of Disposition (interpretary, crematory)	or other place) 3	Date 200 /10/05	C. Location - City or	
ıltin	permit. Pages Department of Important: If it eny injury or o		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		l Air Mem. N 22. Name	and Address of Facility	Leonard J.	Bel Air. Ruck, Inc	Marylanu C.
ä	Depa Impo eny is		1 Hoarti	aen		Harford Road			
-			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat	h. Do not enter the n	node of dying, such as card	diac or respiratory arrest,		Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition resulting in death)	(EREBRO	VASCULA	2 ACCIDE	NT.		Onset and Death
	/Medical Examiner		Tosuming in Godani)	Due to (or as a conseq	uence of): HTP	DM			12 days
	*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				9
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uonno of\:				
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P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 □Ectopi	c pregnancy (specify)		23d. Date of deli Month	ivery Day Year
	s that ned by e deta	by Ph	Part II. Other significant conditions cont	ributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ords	w requires that s been signed b should be deta	ted t	DYSUPDEMA,	PERIPHERA	- VASW	LAR MSEA	SE, 1□Yes	2 No 3 Pr	obably 4 Winknown
Records,	The law re ate has be page 2 sho	Completed	CAROTID ARTE	RY OCCIU	510N - BI	LATERAL	24a. Was an autopsy performed 1 ☐ Yes 2 ☑	d?_ prior to death?	stopsy findings available completion of cause of 2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Othon	Death (Check only one)		PE HABILITATION
of	Physic rthis rat dir	- To	1 ☑ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 3 28b. Time of	DOA 4 Nursin	g Home 5 Residence 28d. Describe how		HOSPITAL
lon	Attending or death. ector: After by the fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division of	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fac	tory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in I	Medical C	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death occur ation and/or investigat	red at the time, date and plicion, in my opinion, death o	ace, and due to the caus occurred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	within To the compl	Me	29b. Signature and title of pertifier	1	1	29c. License number		. Date signed (Monti	h, Day, Year)
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	JUT '		30. Name and address of person who cor Alan Levitt, M.I		m 23a) (Type, Print) Cernan Dri	ve Raltimore	e, Maryland	21207	
	St	ate	31. Date filed / horth, Bayry earl	32. Registrar's Signa		AG DOTETHOL	c, nai yraila	LILUI	
	Regist		man v 1 2003	Book F.	A STORES				

State of Maryland / Department of Health and Mental Hygiepe 0 0 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH OF 20185 Ravmond Herbert Ricketts, Jr. 4:20 F M /Medical 4a Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Lowson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 9. Birthplace (State or Foreign Days 1 € M 2 □ F 218-22-1075 76 February Yrs. Director Maryland Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov treumatic event, the Mcdical Examilinar must be notified at Director MD Baltimore Towson 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 Fairmount Avenue 21204 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WW II I Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I ent: If Item 27 is marked or Raymond Herbert Ricketts, Sr. Theresa ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Elizabeth Ricketts-wife 912 Fairmount Avenue, Towson, MD item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Importent: if any Injury or once. Parkwood Cemetery 3/7/05 Parkville, MD A □ Donation 5 □ Other (Specify) William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road, Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY ARREST HOURS /Medical Due to (or as a consequence of): **Examiner** CARDIAC ARREST 10 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 950 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ filled in by the funeral director, page 2 should be ANOXIC ENCEPHALOPATHY 1 X Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? PERSISTENT SEIZURES performed? 1 ☐ Yes 2 No 1 Yes 2**X** No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Nation 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1XXVatural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation efter death Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours e Funerel I XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signate 29c. License number 29d. Date signed (Month, Day, Year) t 35453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year)
MAR 0 7 2005 7601 CSLER DRIVE TOWSON, MARYLAND 2120 M.D. 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH **Physician** 2005 olores /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. SPITAL 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕏 F Months Hours Min. Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or items 23a or 28a-f ehow 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County or other traumatic event, If a Medical Executiver must be notified at Baltimort 1 Yes 2 No Completed by Funeral Director 10e. Street-and Number 10f. Zip Code 10g. Citizen of What Country? USA ircle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 11) h. +(3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ANKINO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be lary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2106 Department of Health Importent: If item 27 \ohn Oc. Location - City or Town, State 20a. Method of Disposition

1 □ Burial 2 □ Cremation 3 □ F

4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name ⁷3 □Removal from State 3-3-05 Forest Hill, MO 22. Name and Ad less of Facility BALTIMORE, MD 21234. 21. Signature of Funeral Service Licensee EVANS FUREIGO Chapel, 8800 HARRETOIRD KD 23a. Part 1. Enter the disease, or complications that chused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one chuse or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PROBABLE Physician UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical been signed by the attending p should be detached for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 poinths?
1 Yes 2 No 9 Unknow 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time ot death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performes 1 Yes 2 No 25. Was case reterred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 1 🗌 Inpatient 2 2 ER/Outpatrent 3 □ DOA After this 28a. Date of Injury (Month, Day Year) the funeral 28c. Injury at Work? 27. Manger of Death 28b Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

TOXTZCLAW,

2. Registrar's Signature

ted cause of death (Item 23a) (Type, Print) 5601 LCH RAVEN HOVESVAPE

BAKTIMORE, MARYLAND

29d. Date signed (Month, Day, Year)

				State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Death Certificate of Death Reg. No. 0 5								
		Physici	an	1. Decedent's Name (First, Middle, La	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Day Year 3. Time of Death		
		/Medic	cal	KAREN GWEN 4a. Facility Name (If not institution, giv	DOLYN ROBINSO	ON	Ab City Town	or Location of Death		14 28, 30 4c. County of De		
		Examir	er		tuspi rac			LTIMOR		N/A	sa tri	
	r	Funeral		5. Social Security Number 6. S	ex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day OCT 20		lirthplace (State or Foreign Country)	
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		yland now		10a. State 10b. County	10c.	City, Town or Lo	ocation	-			10d. Inside City Limits	
		e Mar la-fst	ctor	MARYLAND N/A		BALT	TIMORE				12 Yes 2 No	
		vith th	Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What	Country?	
		ns 23e	Funeral	4021 BONNER ROAD	12. Was Decedent Ever in	U.S. 13.	2121 Was Decedent of I	.6 Hîspanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	U.S.A	телісал Indian,	
	ဖွ	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or Items 23e or 28e-f show int. the Medical Examinar must be notified at	Fun	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ Xo If Yes, Give	1	If Yes, specify Cub 1 ☐ Yes 2XXIo		o Rican, etc.)			
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Z		lealt		Cornelia S. Robi						Md., 2121		
Robinson	Baltimore,			20a. Method of Disposition X☐ Burial 2 ☐ Cremation 3 ☐	201	. Place of Dispo	osition (Name of matory or other pla			20c. Location - City		
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X	Ball	permit. Pages 1 Department of F Importent: If ite any injury or ot		21. Signature of Funeral Service Lice	1500	WI		BROWN COM		UNERAL HO	ME P.A.	
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24 Date filed (Month Day Your) 32 Projector's Signature	To t To t	Σ	29b. Signature and title of certifier	amilton,	M.D.	AS24	141614-1	B33 /	Navch 1	4,2005		
State 31. Date filled (Mortal, Day, 1941)	5		the transfer of the transfer o	1 Center	300	1 South	· Hanover	Street	Baltimore,	navyland 2122		

amend item#5, perfff, G841.3/14/05 TI State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March 2, **Physician** 2005^{ear} 1:30P M <u>Richard J. Ruszala</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13 N. Montford Avenue Baltimore Date of Birth (Month, Day, Year) 8/30/42 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F 62 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Md n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 N. Montford Ave. 21224 USA filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist <u>Slaysman</u> nd 2 should be filed that and Mental Hygie 27 Is marked other r traumatic evant, III other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Pages 1 and 2 should be trans of Health and Menta tent: If item 27 is marked jury or other traumatic ev John Ruszala Catherine Ochal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret Ruszala 13 N. Montford Ave. Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. 3/5/05 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. \$t. Stanislaus 21. Signature of Funeral Service Licensee Kaczorowski Frei Funeral Home P.A. 21222 Baltimore, Dundalk Ave. Md . 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lidne **Physician** /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 3 Probably 1 🗌 Yes 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 🖢 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To tha Funaral Diractor: A
completely filled in by the for 2 Accident investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital 29a. Certifier 1 🕟 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 01 32. Ricistrar's Signature State 2005 Registrar

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			1- State Registrar Certificate of Death Reg. No. CU 5							0/431
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	Physician Martha V. Stavar [Medical						March 2			10:59 P ^M
								4c. County	of Death	
			Greater Baltimore Medical 5. Social Security Number 6. Sex 7. Age	Center (In yrs. last birthday)	Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	Balti		lana (Chata an Farrian
	Funeral Director		212-34-8236	87 Yrs.	Months Days	Hours Min.	0ct. 10	y, Year)	Count	
			Usuat Residence of Decedent				1000. 10	J, 131/	reim	nsylvania
)	rylan ihow	_	10a. State 10b. County	10c. City, Town or Lo	ocation				10	Od. Inside City Limits
ğ	the Marylan 28a-f show notified at	cto	Md. Baltimore		Towso	on				1 ☐ Yes 2√√No
于	vith th	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of W		try?
3	s 23e	erai	508 Locksley Road	Ever in H.S. 12 1	Was Decedent of H	21204	nosifu Voc or No	7 -	SA - America	an Indian
5	72 hours after death with the Maryland naturel", or Items 23e or 28a-f show lical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No.		If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Blaci	k, White, e	
21215-0036	ursal	by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	W	Mite
500	72 hours "naturel",	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decer	dent's Usual Occup	ation during most of work	rina	16b. Kind of Bu		
\$ 2	within ene. than "i	npie	Elementary/Secondary (0-12) College (1-4or 5	life. I	DO NOT use retired	d)	9			
	filed w Hygier ther th	Col	12 17. Father's Name (First, Middle, Last)		Homemak	18. Mother's Nam	. /Fina baidala		n Hom	ie
出出	buld be fi Mental F arked ot atic ever	Be	Andrew France				_		-	
S Maryland	2 should be filled within and Mental Hygiene. Is marked other than aumatic event, Ine Ma	To.	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Run		ezivints		Code)
S S	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 Is marked other than "naturel", or Items 23e or 28a-1 shoi other traumatic event, the Medical Examiner must be notified at		Mrs. Martha Johnston/Daughte		Snow Hil			, Maryla	101 955	week.
ē,	of Health of Health litem 27 r other tra		20a. Method of Disposition	20b. Place of Dispo			Date	20c. Location - 0	City or Tov	wn, State
Ě	Page nent o int: If		1 Burial 2 □Cremation 3 □Removal from State Graph of the Specify Burial 2 □Cremation 3 □Removal from State	Dulaney Va			7/05	Timonium	n. Ma	rvland
Baltimore,	permit. Pages: Department of timportant: if ite any injury or of		21. Signature of Funeral Service Licensee	1/ 22	2. Name and Addres	ss of Facility Ru				ome, Inc.
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9	Physician /Medical		disease or condition resulting in death)	consequence of):	uec				- 6	weeks
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			IF FEMALE: 23c. If yes, outcome of	of pregnancy				22d Date	of deliver	
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<u>~</u>	Physicien: The this certificate had director, page	Com					perfo	rmed? de	eath? □Yes 2	
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of	Physi this d	. To	1 Yes Hospital: 1 Appatier 27. Manyler of Death 28a. Date of Injur			4 🗆 Nursing no		tence 6 Othe)
o	ding I h. After funer	tion	Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury	Worl	k? Yes 2 □No	200. 10030110011	iow injury occurre	ď	
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ازم	s afte	Certification:	4 Homicide determined building, etc	. (Ѕрвспу)			City or Tow	m, State)		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) Cartifying Physician: To the best of the basis of and manner stale and mann	examination and/or inv	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the deed at the time,	cause(s) and man	ner as sta nd due to l	ted. the cause(s)
	o the vithin i	Mec	one) and manner stat 29b. Signature and title of certifier	0 .	29c. License	e number	20	29d. Date signed	(Month, D	ay, Year)
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	15		30. Name and address of person who completed cause of de	ath (Item 23a) (Type,	Print)	- (- (21204
_	1 /		Kodney W. Wulliam	s.M.D.	110701	1. Charle	es St.	Room 3	213	21204 Baltimore, mo
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	/Medio		4a. Facility Name (If not institution, givens 61 Sher Wood 5. Social Security Number 6. Sex	Road	lact historia ul	4b. City, Town, o	er Location of Death		4c. County of Death Baltim	ore Co.				
	Funeral Director			M 200 F 7. Age (In yrs. I	Yrs.	Months Days		8. Date of Birth Month, Day, Ye Tan, 1	ear) 9. Birthe Cour 1917 M	place (State or Foreign http:)				
	e Marylan 8a-f show	Director	Maryland Bultim	/10 0	ockey	sville			1	0d. Inside City Limits 1 ☐ Yes 2 No				
	ath with the 23s or 21	rai Dire	611 Sherwood	Road			1030		Citizen of What Cour	A.				
900	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ha Medical Examinat natal be rollised at	d by Funerai	11. Marital Status 1 Never Married 2 Married 3 SWidowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 (T) No If Yes, Give Year or Dates:	Į.	/as Decedent of I Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto I Specity:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:					
21215-0036	be filed within 72 hours after death with the Marylan hat Hygiene. ed other than "natural", or items 23s or 28s-1 show event. The Medical Examinat must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade	completed) College (1-4or 5+)	(Give k	ent's Usual Occup ind of work done O NOT use retire	during most of working	ng 16t	Own	fome				
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	rt.		19a. Informant's Name/Relationship (Typ. Nary T Bg 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	tzer 206. PI	19b. Mailing 2644 lace of Disposemetery, crem	Beckl ition (Name of	eysville	Rd. 11	ity or Town, State, Zip	ND, 21102				
Baltimore,	permit. Pages 1 as Department of Hea Important: if item any injury or othe		21. Signature of Funeral Service Ligense	Fan De	spec 1	Name and Addre	Alterna	Aves Fun	eral + Crem	ation Ct.				
	Pnysician /Medical		23a. Part Enter the disease, or comolic shock, of head failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line.					Will have	Approximate Interval Between Onset and Death				
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.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)	у		23d. Date of delive Month	ry Day Year				
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Il Records,				GEI					24a. Was an autopsy performed	prior to con death?	sy findings available apletion of cause of 2 \square			
f Vital	Physicien: this certific al director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatient	3□ DOA Oth	26. Place of Death		e 6 □Other (Specify)				
Division of	ling After uner	ation: T	27. Manner of Death 1 St Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		8d. Describe how in		,				
Divis	P	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	′)			City or Town, St						
	To the Hospitel within 24 hours a To the Funerel Completely filled	edicai	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examin	cian: To the best of my know er: On the basis of examinati and manner stated.	wledge, death ion and/or inve	occurred at the tire stigation, in my o	me, date and place, a pinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)				
)	To t To t	M	29b. Signature and title of certifier	~ ms		29c. Licens	e number	29d.	Date signed (Month, L	Day, Year)				
	6		30. Name and address of person who cor		A	rint)	re 201 1	1.1.1- 1/4	Hley Mo	21030				
	Sta Registr		31. Date filed Man Dir. Paging	32. Registrar's Sifuati	4		CW	10,01 V)	וונק איט	21070				

State Registrar 31. Date filed (Month, Day, Year) MAR 0 7 2005 111 Penn Street

Baltimore, Maryland 21201

amend item#18, perFH, G841, 3///05 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:17 P M SOBER MARCH NORMAN 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) AUG. 6, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ₹ M 2 □ F 85 Director 213-16-5416 MD Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD BALTIMORE BALTIMORE or 28e-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 Items 23a 35 STONEHENGE CIRCLE #6 Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 5 Baltimore, Maryland 21215-0036 f Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify: WHITE Specify: 3 Widowed 4 Divorced 'naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR/PHARMACIST PHARMACY of Health and Mental Hygie fitem 27 Is marked other ir other treumetic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil timent of Health and Mental H tent: If item 27 is marked ott jury or other treumetic even HERMAN **SOBER** RACHAL Racheal **SNYDER** 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HILDA SOBER / WIFE 35 STONEHENGE CIRCLE #6 - BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of In portent: If eny njury or BNAI ISRAEL CEMETERY 03/04/2005 * 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EN1) STAG HC2 HEIMERS Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 12 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 20 No 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ۴ 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Natural s after de-rel Director: After investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signat to and title of certifier D nour me and address of person which completed cause of death (Item 23a) (Type, Print) BACROMDZIZER AKHANI 7220 TINGEM 32. Registar's Signature 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygiene 1 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 3, ^{Day} 2005 Year **Physician** CYNTHIA SMITH 10:25a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE MANORCARE HEALTH SERVICES TOWSON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F 216 76 1958 Director SEPT. 6, 1949 MARYLAND 55 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other treumatic event, the Modical Examinational be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD BALTIMORE TOWSON Completed by Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 509 E. JOPPA ROAD 21286 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HENRY SMITH SWANLOLA GILES 19a. Informant's Name/Relationship (Type, Print) KEMP SMITH (UNCLE) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 N. WASHINGTON ST. APT. 708 BALTO, MARYLAND 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) TRINITY CEMETERY MARCH 10. 2005 BALTIMORE, MARYLAND Signature of Funeral Service License 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTIMORE, MARYLAND 21213 nadine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsetland Death Immediate Cause (Final disease or condition resulting in death) Pnysician Munon /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualty (or as a consequence of) Examiner the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnam 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 Q No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 🗋 Accident Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 027569 3/9/05 1838 Greene Free Rd 21208 M completed cause of death (Item 23a) (Type, Print) 30. Name and ddress of person eman MAR 0 7 2005 32. Registrar's Signature State Registrar

		•	1- State of Maryland / Department of Health and Mental Hygiene 0 5 07436 Certificate of Death Registrar	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	
	Physici		MARGARET M. SMITH MARCH 2 ^{Day} 2005 4:55 pt	vi
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
			GENESIS ELDERCARE - HERITAGE DUNDALK BALTIMORE	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign	חק
	Director		212-28-9539 1 M 2D F 91 Yrs. Months Days Hours Min. (Month, Day, Year) Country) MARYLAND	
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	the A	Director	MD BALTIMORE DUNDALK 1 1 Yes 2 No. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
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93	urs a	þ	3 ☑ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ☒ No Specify: Specify: WHITE	
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nd		Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame)	
Maryland		၉	HERBERT THOMAS BREWER JONES	
lar	C 00		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	^
	C = 0 =		MRS. MARY C. BAKER 101 CENTER PLACE APT. 311 BALTO., MD. 2122	2
O.	Prof	1 3	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Ë	nit. Pag artment ortent: I injury o injury o		*4 Donation 5 Other (Specify) BAYVIEW CREMATORY 3/7/05 BALTIMORE, MD.	
Baltimore,	permit. Pag Department Importent: any injury once.		21. Signature of Funeral Service Licensee KACLOROWSKOTFaciFUNERAL HOME P.A.	
	40 7 8 Q		1201 DUNDALK AVE. BALTIMORE, MD. 21222	
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Onset and Death Due to (or as a consequence of):	
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687	icate physi s the I	dicai	d. DETTENT	
×	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Вох	atter after I for u	ciar	in the past 12 mogths? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	
o.	to the de by the a tached	iysi	1 Yes 2 PNo 9 Unknown 9 Unknown	
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rds	quires n sign	d by	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown	n
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Re	The tav cate has page 2	mc d	performed? death?	
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>	Physicien: this certific ral director,	O B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
J Of	g Ph er thi	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	_
io	Attending I r death. Bctor: After by the funer	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	
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Ö	tal or	Certification	Sullarity, Ste. (Specify)	
	hour hour uner		29a. Certifier (Check only (Ch	
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	ledicai	one) and manner stated.	
	To To	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
•	do		Emple ((1600, M1) D21108 21905	
	101		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	,
	U		Sander Willes 2 Marles Place D Gordolle MI) 2,222	-
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
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			1 - For State Registrar	State of M	aryland		artmeni rtificate			and M		giene Reg. No.	005	07437
Ri	Physici /Medi	cal	1. Decedent's Name (First, Middle	VINCEN			Tr	ott	Ta	4 Dooth	2. Date of Dea	Day 05	Year 2005	3. Time of Death
	Examir Funeral	ier	4a. Facility Name (If not institution The Johns He 5. Social Security Number	6. Sex 7. A	pita age (In yrs. las	st birthday)	If Under	alt	If Under a	2	8. Date of Birt (Month, Da 7 – 18 –		9. Birth	place (State or Foreign
	Director		217-52-7410 Usual Residence of Decedent 10a. State 10b. County	1 ⊠ M 2□F		Yrs.	ocation	Days	riouis	TVIIII.	7-18-	1951		timore, MI
	with the Mary cor 28e-1 sh be notified	Funeral Director	MD n/a 10e. Street and Number 213 S. Grund	37 C+	Bal	timo	10f. Zip		4			_	of What Cou	1≹Yes 2 □ No intry?
-0036	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or itams 23c or 28e-1 show event, the Modical Exerciter must be rotified at	by	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Morried 15. Decedent	12. Was Deceder Armed Forces ed 1 Yes 2 If Yes, Give Year or Dates	i? X No :	16a. Dece	Was Deced If Yes, spec	No No	spanic Origin, Mexican Specify:		ecify Yes or No- Rican, etc.)	Sp	Race - Ameri Black, White, ecify: Whi	ite
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	es 1 and 2 of Health fitam 27 i		John Trotta 20a. Method of Disposition 1 Burial 2 XCremation		20b. Plac	ce of Dispo netery, crei	osition (Nam matory or ot	ne of	9)		ate	20c. Locat	ion - City or To	
Baltimore,	permit. Pag Department Important: I any injury o once.		4 Donation 5 Other (St. 21. Signature of Funeral Service)		Gre	eenmo	2. Name and	d Addres	s of Facility	y Jos	eph N.	Zan	imore, nino, ore.M	MD Jr. FH D 21224
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			1- For State of Maryland / Department of Health and Mental Hygiene 0 0 5 0 7 4 3 8 Certificate of Death Reg. No.
	Physici		1. Decedent's Name (First, Middle, Last) MARY WOODARD 2. Date of Death Month Day Year 5:15 A M
	/Medic Examir	~ ~	4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF CATONSVILLE CATONSVILLE CATONSVILLE Ac. County of Death BALTIMORE
	. Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 F 1 M 2 M Months 1 M Min. 2 M Min. 3 Days Hours Min. 3 Min. 3 Pknkbkk 12/19 2 F 1 M Min. 4 Min.
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23s or 28e-1 show other traumatic event, the Medical Evanties must be routiled at	rector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits HD N/C BAHIMUK. 10g. Citizen of What Country? 10a. Street and Number 10c. City, Town or Location 10d. Inside City Limits 12c. City Limits 12c. City Limits 10d. Inside City Limits 12c.
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Mary	d 2 sho th and I th and I trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23.9 Pouls Color Buy
Baltimore,	Pages 1 and intention of Health nt: If item 27 ry or other trans		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary crematory or other place) Date 20c. Location - City or Town, State
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee 2 Attack Betts 1 Paurial 2 Cremation 3 Removal from State CANVERY CEMETER 1 3/8/05 Huntsvills Va 22. Name and Astress of Facility BEHS Funeral Home 129 N. CANSINE 5.4 Bartimung, 410 21213
The state of the s	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CROWARY ARTERY DISEASE
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O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
rds, P.	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GASTRO INTESTINAL BLEEDING. 1 Yes 3 Probably 4 Unknown
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Division	tel or Attencts after deathers al Director:	Certification:	3 Suicide 4 Homicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To To con	2	29b. Signature and delte of certifier PHY SICIAN. 29c. License number 29d. Date signed (Month, Day, Year) MARCH 02 2005
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5310 OLD COURT ROAD AVVERAHALLI M HARISH 301T & 303 MD 21133.
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 7 2005 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBMOARY 28, 20135 2:32A WEBER AUG UST /Medical 4b. City, Town, or Location of Death 4a Facility Name (Itnot institution, give street and number) Saint Joseph Medical Center 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 ☐ F Yrs. Director 214.03.2199 MARYLAND 10.17.1916 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 Tyes 2 No Director OLIVER DALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Items 23a SKANK 7006 21220 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. If item 27 is marked othar than "natural", or Items 23. Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 &Yes 2 \(\text{No.}\) \(2 \) No If Yes, Give Year or Dates: 43.46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 E No þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BAILDING CONTERTER - EMPLOYED 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RACHAE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra WIFE .O. BOX HASE 'WD 21027 VIRGINIA L. WEBER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 SCremation 3 ☐ Removal from State EVANS FUNERAL -05 FOREST HILL, MD - 2. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility PEACEFUL ACTERNATIVES 21. Signature # Funeral Service Licensee RD YORK M01220 2325 TIMONIUM, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIOMYOPATHY YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner transit The law requires that the death certificate be executed CORONARY ARTERY DISEASE YEARS that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien are hed for use as the burial. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b 24a. Was an autopsy performed? 1 🗌 Yes Division of Vital 1 ☐ Yes the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XInpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 XNo this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Lebruary 28, 2005 D 17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 ABDALLAH J. HELOU 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 7 Registrar

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	For State	State of Maryla		artment of He rtificate of D			200	5 07110
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Examiner			- Lal	4b. City, Town, or I	Location of Death	././	4c. County of D	Death
<u> </u>	5. Social Security Number 6. So	eral 405	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	Na Data of Birth	N/A	Bish-less (Octoor 5
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Priysician	232 Part1. Enter the disease, or control shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	one cause on each line.	atin. Do not ent	er the mode or dying,	, such as cardiac (or respiratory arre	9\$1,	Approximate Interval Between Onset and Death
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Box 68760, eath certificate be executed attending physician and for use as the burial-transit	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy			23d. Date of	
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- h	30. Name and address of person who o	ompleted cause of death (It	em 23a) (Type,	Print)		1 - 2 2 - 1	1/2001	<u>_</u>
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	10		30. Name and address of person who cor				A					
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ı	Sta Regist		31. Date filed (Month, Day, Year) FEB 2 5 200!	32. Pegistrar's Sign	nature	- M						

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Markus Neal Allen unpend item#23a, 27, perME, G841,3/30/05 TT of Health and Mental Hygiene 0 0 5 05-01404 RJ1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 23, 2005 NEAL ALLEN **Physician** ARKUS 04:18 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Center Clinton Prince George's 6. Sex 1 M 2 □ F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct - 4, 200 Birthplace (State or Foreign Country) Funeral Months Hours Min 214-71-0869 Md. Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Prince beorge 1 ZYes 2 □ No Clinton Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ U.S.A. Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1□ Yes 2□ No Specify: Black Specify: 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: If them 27 is marked othe any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SHAWNNETTE 19a. Informant' Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHAWMMETTE HIL MAR CIRCLE WEST FORESTYLLE MD. 20147 Allen 6113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Leensee VCT CEM. Much 6,05 Frederich Md.
22. Name and Address of Facility GARLY Collins Frederic None MT. OLIVET COM. FREA. MS. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privalcian a Sudden Infant Death Syndrome /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

11 Yes 2 □ No autopsy performed? /es 2 \(\square\) No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 2 XER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 2 No 2 Accident I Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State of Maryland / Department of Health and Mental Hygien 2 0 5 For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Addison Year **Physician** 7:45 A M Rochelle 8 2005 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Frederick West South 9t. Frederick 30 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
| Days | Hours | Min. | (Month, Dey, Yeer) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 1 F 219-80-5045 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f ehow other traumatic event, it is Medical Examiner must be notified at 1 ✓Yes 2 □ No Frederick Frederick Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? West South 21701 U. S. A. Ітете 23е 307 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mentat Hygiene. Important: If Item 27 is marked other than "natural", or Itement injury or other traumatic event, it a Medical Examinat 1 Never Married 2 Married 1 ☐ Yes 2 1 No Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Disabilit 11 th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert H. Addison SR. Foreman Cmma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (mother) South St Frederick Md 21701 Naylor 307 West Emma 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Sfate 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Ebenezer UMC Chydrony 2-24-05 FREDERICK, * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address & Family FUNTIALITOME 21. Signature of Funerat Service Licensee Say I. ollis WEST SOUTH ST PREDERICK MD 21701 110 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) METASTATIC CERVICAL CHNCER **Physician** 3 MONTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did fobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a Was an autopsy performed? Yes 2 No certificate has 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗙 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: at or Attending Patter death. 1 Naturaf 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature an 123/2005 WD D0056314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BINDU GEDPGE 46 B THOM JOHNSON DRIVE THOMAS 31. Date filed (Month Day Year) 32. Rustrar's Signature 2005 State Registrar

Physician / Medical Examiner 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year FEBRUARY 13, 2005 5:05A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death GILCREST HOSPICE CENTER TOWSON 5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Month Day Year Month Day Month Day Year			1 - For State Registrar	State of Marylan	•	artment of H			iene eg. No.200	5 07445
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Approximate in Approx	the Head		20a. Method of Disposition	20b. F	Place of Disp	osition (Name of	0)	Date	20c. Location - City	or Town, State
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Jana Black MD 20061199 Feb. 13, 2005	the the	Ved		and manner stated.		29c License	e number		29d. Date signed /M	Ionth, Day, Year)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tason 18/ack 660 I North Charles Ave Baltimore M 3 21204 State 31. Date filed (Month Day, Year) 32 Registrar's Signature	17		Jorda 18	Q U				1		
State 31. Date filed (Month Day, Year) 32 Degistrar's Signature	10		30. Name and address of person who o	completed cause of death (Ite	m 23a) (Type	, Print)	י פנ	4.	, \ 0	(2.42)
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Registrar FEB 1 8 2005 Rouse & Sparke			FEB 1 8 20	32 negistrar's Sign	de de	arte				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 903 **Physician** JOHN PAUL AMBROSE PM 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Emmitsburg

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. (Month, Day, Year) | March | 14, 1917 St. Catherine's Nursing Center Frederick 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Maryland 1 ★M 2 F 87 219-36-4844 Director Usual Residence of Decedent death with the Maryland 10b. Count 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene.

Set 12 Is marked other then "natural", or Items 23a or 28a-f show ther treumatic event, the Medical Examinat must be notified at 1 Tyes 2 □ No Funeral Director Maryland Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 331 South Seton Avenue 21727 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Mechanic Victor Cullen 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Roger Ambrose Grace Irene Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 Is y or other tre Lorraine Hays (Sister-in-law) 25324 Highfield Road, Cascade, Maryland 21719 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Weller Cemetery 2/21/05 Thurmont, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Livensee ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. MAIN STREET, THURMONT, MD 21788 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner physician and s the burial-transit The taw requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2☐No the 9 Unknown 9 Unknown ģ Other significant conditions contributing to death but not resulting in the underlying cause given in P 23e. Did tobacco use contribute to the cause of death? Records, Ne nole 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 Yes Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined after 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month. Dav. Year) License number 29b. Signature and title q 29c. 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan L. Carroll, MD 310 South Seton Avenue, Emmitsburg, Maryland 21727 8 2005 distrar's Signature 32. R State Registrar

			. For	State of Maryland				-	•	73 00 1 t was
			- State Registrar		Cer	tificate of	Death	Reg	9. No. C U U D	0/44/
	Physici	an	1. Decedent's Name (First, Middle, Las	st)				Date of Death Month	Day Year	3. Time of Death
	/Medic			Edward M. E	Brown			February		3:30p M
7	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	
			Montgomery General 5. Social Security Number 6. S		ast hirthday)	011 If Under 1 Year	ney If Under 24 Hrs.	8 Date of Birth	Montg	omery hplace (State or Foreign
	Funeral Director			X 2□F 76	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) Feb. 29,	(ear) Co	aryland
١.			Usual Residence of Decedent	70				ren. 299	1)20 11	ir y ranu
	rylan ihow	_	10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside City Limits
	e Ma Sa-1 s	Director	Maryland Montgo	nery Dama	scus					1 ☐ Yes 2 No
	vith th	Dire	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Co	ountry?
	s 23e	eral	12121 Prices Dist	illery Road 12. Was Decedent Ever in U.S	2 12 V		0872 dispania Origin? (Sp		United St	
	Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ★ Married	Amed Forces? 1 ☐ Yes 2 五No	5. 15. ¥	Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
99	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify:	Nhite
200	within 72 hours after death with the Maryland ene. then "naturel", or Items 23s or 28e-1 show he Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Deced	ent's Usual Occup	oation during most of work		6b. Kind of Business/	Industry
2	ithin 19.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retire	d)	9		
7	e filed withi al Hygiene. I other ther vent, I'E.N		9 17. Father's Name (First, Middle, Last)			Painter	T .	e (First, Middle, Ma	louse Pain	ting
and	ould be fi Mental H arked ot atic ever	Be	Willard Brown				Sarah Ki		siden Sumame)	
Maryland 21215-0036	should Ind Men	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	a Address (Street			City or Town, State, 2	Zip Code)
S			Betty E. Brown/						amascus,	
<u>5</u>	s 1 and 2 f Health item 27 l	n i	20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of natory or other pla			Oc. Location - City or	
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m	permi Depa Impo any ir		fodel 8	Upm	26	401 Ridg	e Road, D	amascus,	Maryland	20872
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
4	Physician	(i. l	Immediate Cause (Final disease or condition	a Asystolia						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):					
	LAdiffille	L	Sequentially list conditions,	b. Concestive F	leart]	Failure				
	ed isit	nine	if any, leading to immediate cause (Disease or injury		erice oi).					
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c. COPD Due to (or as a consequ	ience of):					
760,	siciar siciar buria	calE		Bladder Cano	er					
687	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	edic								
Вох	h cert endin use	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	v		23d. Date of del	,
	death	Sicla	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	4 Pregnant at time of de		Other (specify)	y		Month	Day Year
P.0	that the de led by the a detached f	Physiclan/Medi	9 Unknown					on- Bidsel-		. the course of death?
Ś	ires tha signed d be det	by	Part II. Other significant conditions of	contributing to death but not resu	liting in the ur	nderlying cause gr	ven in Parti.	23e. Did toba	icco use contribute lo	obably 4 Unknown
orc	w requir been si should	eted								
Record	e law has b	Completed						24a. Was an autopsy performe	prior to	itopsy findings available completion of cause of
E E	ysicien: The list certificate hadirector, page							1 ☐ Yes 2	No 1 □ Yes	2 No
of Vital	Physicien: this certificatal director, present	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 1	FB/0	ott	200	h (Check only one,		-:4.3
	Phys r this aral di	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Inju	ry at	28d. Describe how	ce 6 Other (Spe v injury occurred	cny)
on	nding I th. : After s funer	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury	M 1	rk?]Yes 2□No			
Division	I or Attendii after death. Director: A I in by the fu	iffice	3 Suicide 6 Could not be determined		me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	s afte	Certification;	Tomodo	building, ste. (Specify				ony or yourn,	J. 4.07	
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical Exal	nysician: To the best of my knowniner: On the basis of examinat						
	the hin 2, the mplet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c, Licens			d. Date signed (Mont	
1	T vil	_	A M.		1	M // -	2	200	1.41	
7			30. Name and address of person who	completed cause of death ()4	230) (Trees	1-140 /	>	3	118100	
	10		Kathleen McShane	•			Rockville	Marulan	d 20850	
	St	ate	31. Date filed (Month, Day, Year) FEB 22	2005 32. Anistrar's Signat		William,	WOCKATTTE.	narytan	الرنان عيا	
	Regist		LER % %		1					

LEA B.MORRILL 05-1151

Amended Items 24a & 24b per M.E. 02/15/2005 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-1	151		1 10400	State of Ma	ryland / Depa	artment of H	ealth and	Mental Hvgi	ene) (o c	07110
		•	For State Registrar			rtificate of L			g. No.	07448
	• • • •	44	1. Decedent's Name (First, Middle, L	.a st)				2. Date of Death Month	Day Year	3. Time of Death
,	Physicia /Medic		Lea Brandi Barne	s-Morrill				FEBRUAR		.0:22a [™]
}	Examin		4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town, or		n	4c. County of Death	
		ķ	1512 WASHINGTON E 5. Social Security Number 6.		(In yrs. last birthday)	WESTMINS If Under 1 Year		8 Date of Birth	CARROLL	ce (State or Foreign
	Funeral Director		218-21-0324	1 M 2 🔭	24 Yrs.	Months Days	Hours Min.		Year) Country	MD
	ס		Usual Residence of Decedent					1-1		
	arylar ahow	_	10a. State 10b. County		10c. City, Town or Lo				100	I. Inside City Limits 1 ☐ Yes 2 🛣 No
	he M	ectc	MD Carr 10e. Street and Number	oll	Westr	ninster 10f. Zip Code		10	g. Citizen of What Country	
	with Sa or	ij	1512 Washington	Road			1157		USA	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-f ahow ther than "natural", or Items 23s or 28s-f ahow ent, the Medical Examinative rust be multified at	Funeral Director	11. Marital Status	12. Was Decedent E	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Race - American Black, White, etc	
9	after or Ite	/Fui	1 Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 XN If Yes, Give	lo l	il Tes, specily cuba 1 ☐ Yes 2 ☑ No	Specify:	o ricari, etc.)	Specify: Whi	
003	ural',	d by	3 Widowed 4 Divorced	Year or Dates:		dent's Usual Occup				
7	in 72	Completed	15. Decedent's (Specify only highest g	grade completed)	(Give	kind of work done of DO NOT use retired	during most of wo. f)	rking	6b. Kind of Business/Indus	Stry
212	d with giene. rr than	mo	Elementary/Secondary (0-12)	College (1-4or 5		Jnemployed	đ		N/A	
pu	al Hygar Hother	Be C	17. Father's Name (First, Middle, La	st)				m <i>e (First, Middle, N</i>	·	
yla	ould b Ment arked	ည	Rodney Barnes					ara K. Mo		
Maryland 21215-0036	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship Rodney Barnes/f			ng Address (Street a Ridge Av			City or Town, State, Zip Cotown, PA 17	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, it a Medical Examinst in usi be notified at ODGs.		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City or Town	
jo L	bages ent of nt: If it		1 ☐ Burial 2 ☐ remation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State		matory or other place Cremation		2/18/2005	Hampstead,	MD
Baltimore,	mit. F partm sortar / injur		21. Signature of Funeral Service Lic						anol DA	
ä	permi Depa Impo any ir	1 8	John K A			112 Washir	ngton Ro	ad Westm	inster, MD	21157
			23a. Part . Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lir	the death. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory arre	II II	approximate hterval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Haui	aina					
	/Medical- Examiner		Toodxing in dodain,	Due to (or as	nsequency of):					
	# # #	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence of):					
	ate be executed hysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
,092	be executed ician and burial-transit		resulting in death) Last	Due to (or as a	a consequence of):					
876	cate b	dical		d						
89 X	death certificat e attending phy d for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of delivery	
Вох	atten after u	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				ay Year
o.		hysi	9 SUnknown	9□ Unknown						
S, D	The law requires that the te has been signed by the age 2 should be detache	by P	Part II. Other significant conditions	s contributing to death be	ut not resulting in the u	ınderlying cause gıv	en in Part I.		acco use contribute to the	
Records,	* requir been si should I							1 UYe	s 2 No 3 Probab	oly 4 □Unknown
ec	e law I has b	ompieted						24a. Was ar autopsy perform	prior to comp	y findings available pletion of cause of
alF		O						18€ √os 2	X No 2	□ No
Vital	Physician: This certifical	o Be	25. Was case referred to medical examiner? 1X Yes 2 □ No	Hospital:	nt 2 ☐ ER/Outpatie	nt 3 DOA Oth		ath (Check only one	nce 6 Cy ther <i>(Specify</i>)	ICIL DOTE
of			27. Manner of Death	28a. Date of Injur	rv 28b. Time o	iii di Ben		28d. Describe ho		CF.NE
ion	Attending r death. sctor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigat	tion Found 2/13	5/05 Four lois		Yes 2 Wo	Decease	ed harged.	self
Division	ir Atte ter de irecto	Certification:	3 Suicide 6 Could no determine		ury - At home, farm, st	. 0		City or Town	reet and Number or Rural F State) 1512 Wash	motore Del
	urs af eral D eral D			Di di Santa di Santa di Santa di Santa di Santa di Santa di Santa di Santa di Santa di Santa di Santa di Santa	"hou			Westwar	ster, MDZ115	Flarrolleo,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	caminer: On the basis of and manner sta	f examination and/or in	nvestigation, in my o	pinion, death occ	urred at the time, da	use(s) and manner as state ate and place, and due to the	10 cause(s)
	ro the within ro the comple	Me	29b. Signature and title of certifier	1 11	1	29c. Licens		29	d. Date signed (Month, Da	ıy, Year)
	WIL		MILLS	In M	/(OCM	Œ	FI	EBRUARY 14, 2	2005
	W6		30. Name and address of person wh	no completed ause of d	eath (Item 23a) (Type		C+	D = 1 · ·		1 01 001
			S. V. HO	14 A Paris	ar'e Signatura	TIT Leu	n Street	Baltimo	ore, Maryland	. 21201
: -	Sta Regist		31. Date filed (Month, Day, Year)	5 2005 Se	ar's Signature	1				
1		15	I LLU I	O LUUU KA	STAR A ATO	Magall 8				

		1- For Amend Item Registrer	24a per Ve	erb.,	G84156	3707/	osat e of t	Death	and w	ientai i iy	Reg. No	70 U s.	0	0/449
Phys	cian	Decedent's Name (First, Middle, L.	ast)	Ω	ARR					2. Date of Do Month	eath Da	ıy f	Year	3. Time of Death
/Me	lical	BERTIE	THYE		MKK	-				2_	10	10	55	1725 M
Exan	iner	4a. Facility Name (If not institution, gi				4b. City, 1	Town, or	Location of	of Death		40	. Count	y of Death	
France		Garrett Co. Memor 5. Social Security Number 6.			ast birthday)	Oakl If Under		If Under	24 Hrs.	8. Date of Bi		arre		place (State or Enreign
Funera Directo			1□M 2∏F	45	Yrs.		Days	Hours	Min.	(Month, D	ay, Year,)	Balt	olace (State or Foreign ntry) LIMOYE, MD
p.		Usual Residence of Decedent		1										
arylar show	_	10a. State 10b. County		1	, Town or Lo								1	10d. Inside City Limits
he M	Director	WV Grant		Pet	ersbur									1 ☐ Yes 2 ☐ No
death with the Maryland rms 23a or 28a-f show rmust be neithing at						10f. Zip (10g. Ci	tizen of	What Cour	ntry?
eath	Funeral	HC 33, Box 3197	12. Was Decedent	Ever in U.S	S. 13		847	snanic Ori	ain? (Sne	cify Yes or N	USA		ce - Americ	an Indian
or iter	F	1 □ Never Married 3 Married	Armed Forces?			f Yes, speci	ify Cubai	n, Mexican	, Puerto	Rican, etc.)		Bla	ck, White,	etc.
Tail.	à	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		į	1□Yes 2	2 ∏ No	Specify:				Specif	y: Whi	.te
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d be d be ced o	Be	71 77										Cuman	110)	
Shoul nd Me mark	2	19a. Informant's Name/Relationship		-	19b. Mailir	na Address				S Huds		or Town.	State. Zip	Code)
ING 2 alth a strike a 27 is		Steven Edward Bar	r, Sr.							rsburg				,
Baltimore, Maryland 21215-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumetic event, the Madical Examiner must be natified at		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Nam-	e of	1		ate			- City or To	own, State
Page nent cannot in		1 ☐ Burial 2√☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Spec		1	risonb	-			2-15	-05	Har	risc	onbur	g, VA
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n gore	X	23a. Part 1. Enter the disease, or con	5/ JAS/	494	- P	OB 400	0 -	Patar	shur	VIJ.	-26 8	47		
icate be executed Examination and physician and street burial-transit	ı	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as Due to (or as	a consequ	tc /	ng	ja t (anc	er					
the death certily the attending y the attending ched for use a	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre							te of delive	ery Day Year
dS, Fullines that signed be detailed	d by P	Part II. Other significant conditions	contributing to death b	ut not resu	lting in the ur	nderlying car	iuse give	n in Part I.			obacco i Yes 2			e cause of death?
VITAI MECOTGS, siclan: The law requires t certificate has been signe rector, page 2 should be e	Completed									24a. Was	an	24b 1	Were autor	nsy findings available
he lav e has	E C									auto	psy rm <i>e</i> d?		death?	psy findings available npletion of cause of
	0	25. Was case referred to medical						26 Place	of Death	1 Yes	2 ₩ No		1 🗆 Yes	2 No
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n OT og Phys ter this neral di	l.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry v Year)	28b. Time of Injury	28	Sc. Injury Work	at		8d. Describe				<u>, </u>
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		Mary Babb +	Randoft (an	ur 1	ente	1	+ 1/1	ul (Cfr. D	nve		1000	auteun
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I 2 ☐ Cremation 3 ☐ Removal from tion 5 ☐ Other (Specify)	DOL DICE	203 Red	reet and Number or I Lion Bra	Rural Route Numbe nch Rd	er, City or Town, S Millin	State, Zip Code) gton, MD 216
tion 5 Other (Specify)	ZUD. Place	e of Disposition (Name of etery, crematory or other	of place)	Date	20c. Location - 0	City or Town, Stete
		erans Cem		22/2005	Hurlo	ock, MD
of Funeral Service Licensee		22. Name and A	ddress of Facility	nhain &	Newnar	m Funeral Ho
en dellar		370 W	Cypress	St Mi	llingto	on, MD 21651
nter the disease, or complications that or heart failure. List only one cause on	caused the death. I	Do not enter the mode of	dying, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
ause (Final andition	As proto	not For	10 DE	d N	<u>/</u>	Oriset and Death
eath) Due to	(or as a consequen	ce of):		0/1		
ist conditions.	Cot as a consequen	ce of:				
Underlying See or injury	(or as a consequent	GG 01).		WIM	<i>M</i>	VAMINE
events c. Due to	o (or as a consequen-	ce of):		TOU ADDROV	ED BY MEETCALE	Arm.
d			CER	TIFICATION		
cedent pregnant		ath 3 Ectopic pregn			7	e of delivery nth Day Year
2 □No 4□Preg		h 5 ☐ Other (specif	y)			,
	death but not resulting	ng in the underlying caus	e given in Part I.	23e. Did t	tobacco use con	ribute to the cause of death?
ous Carde	ac Pu	1/ xux	o gron ar r ar r			3 Probably 4 Unknow
		00		24a Was	an #4h V	Were autopsy findings availab
				auto	psy primed?	prior to completion of cause of death?
reterred to medical			26 Place of C			Yes 2 No
Plosnital:	Innatient 2 ER	VOutpatient 3 ☐ DOA	Other			er (Specify)
Death 28a. Date	e of Injury 28					
al SCIrending		M	1 ☐ Yes 2X No	Subjec	t choked	on gum
de 6 Could not be 28e. Plac	ce of Injury - At home		fice	28f. Location (City or To	Street and Number	er or Rural Route Number,
	at home			203 Red	Lion Br	anch Rd.
only 2 Medical Exeminer: On the	basis of examination	edge, death occurred at the and/or investigation, in	he time, date and pla my opinion, death o	ce, and due to the curred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
		29c. L	cense number	3/	29d. Date signed	d (Month, Day, Year)
d address of page the completed cal	use of death (Item 2)	3a) (Type Print) •	13603	<i>f</i>	THE P	Alrok.
opeer Kd Blac	ga Ch	estertou	on, MD	21420) JV 3	hamahan
	Hegistrar's Signatur	M A	i i			
المنافعة المساوية المساوية						
assessink and a second a second and a second and a second and a second and a second a second and a second and a second and a second and a second and	er Underlying ease or injury devents death) Last Due to devents death) Last C	Due to (or as a consequent of pregnancy past 12 months? es 2 No es 2 No enknown Second to pregnant past 12 months? es 2 No enknown 1	Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1	death) Last Due to (or as a consequence of): Due to (or as a consequence of (or as a conse	Due to (or as a consequence of): CERTIFICATION APPROVED CERTIFICAT	Due to (or as a consequence of): d. CERTIFICATION APPROVED Bit

			1 - For State Registrar	State of M	larylan		artmen <i>tificate</i>				_	giene Reg. No	2001	0.74	5
	Physici /Medic		1. Decedent's Name (First, Middle, La Hermine Winnie								2. Date of De Month 02	path Da 15	y Yea 2005	3. Time of Dec	
7	Examin		4a. Facility Name (If not institution, give						Location				. County of De		
			14400 Homecrest 1 5. Social Security Number 6.5			last birthday)	Silve If Under		pring If Under		8. Date of Bir	th	ontgome		reian
	Funeral Director			_M 2∰F	91	Yrs.	Months	Days	Hours	Min.	07/22/	1913	3. 2	hirthplace (Stete or Fo Country) NY	
	Maryland f show	or	10a. State 10b. County MD Montgome	ery		y, Town or Lo Lver Si			<u> </u>					10d. Inside City L	
	r 28a-	irect	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What	Country?	
	th with	alD	14400 Homecrest	Rd Apt# 22	21		209	906				Uni	ted Sta	ates	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? (No	1	Was Deced f Yes, spec 1 ☐ Yes 2				ecify Yes or No Rican, etc.))-	14. Race - Ar Black, W Specify: W		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural;, any injury or other traumatic event, the Medical Exagnes.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade <i>completed</i>) College (1-4or	5+)	16a. Deced (Give life. I Homes	dent's Usua kind of wor DO NOT us naker	l Occupa k done d e retired	ation furing most	t of worki	ng		and of Busines Home	ss/industry	
	uld be filed fental Hyg rked other lic event,	To Be C	17. Father's Name (First, Middle, Last Max Winkler)							(First, Middle nknown	, Maider	Sumame)		
Maryland	nd 2 shou lith and M 27 is mar r traumat		19a. Informant's Name/Relationship				•	,					or Town, State		
Baltimore,	ages 1 au ant of Hea at: If item y or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special		3	Place of Dispo emetery, crer		ne of ther plac			/2005		ocation - City	or Town, State	
Baltir	permit. Para Departmen Important any injury once.		21. Signature of Funeral Service Lice		20			d Addres Rina ew H						g,MD 20904	
Name and	Fnysician /Medical Examiner	ıer	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to inmediate cause. Enter Underlying Cause (Disease or injury)	plications that cause one cause on each a. Cerebry Due to (or a b. Due to (or a)	line. Voscu s a conseq oscle:	lar Accuence of):	er the mode	e of dying	g, such as	cardiac c	r respiratory a			Approximate Interval Batwae Onset and Dea 72 Hours	en th
68760,	certificate be executed ding physician and use as the burial-transit	edical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or a	s a conseq	uence of):									
.O. Box	death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	I death 3	Ectopic production of the second seco			·			23d. Date of o Month	delivery Day Yeai	r
Q.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions Diabetes Melli		but not res	ulting in the u	nderlying ca	ause give	en in Part I.			tobacco Yes 2		to the cause of death	
Vital Records,	The la ate has page 2	Completed									1 Tes	psy ormed? 2 XN	prior t death	autopsy findings ava o completion of caus ? es 2 \sumbox No	ilable e of
Vit.	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{X} \) No	Hospital: 1 ☐ Inpat		ER/Outpatier	ıt 3□ DO	Othe			(Check only o		6 □Other (Si	/4-/	- 1
on of	Jing After fune	tion: To	27. Manner of Death 1 Anatural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury	28b. Time o Injury		8c. Injury Work		1	28d. Describe			овсту)	
Division	al or Attendii s after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not lead to determine determined	e 28e, Place of I	njury - At ho etc. (Specif	ome, farm, str y)	eet, factory	, office			28f. Location (City or To	Street ai wn, Stat	nd Number or e)	Rural Route Number,	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C		nysician: To the bes	of examina										
		M	29b. Signature and title of certifier	rech			290	D098	number 334				ate signed <i>(Ma</i>	nth, Day, Year)	
	12		30. Name and address of person who Barry N. Rosemba	completed cause of um, MD 372	death (Item 20 Fa:	rragut	Ave	Kens	ingto	on, M	D 2089.	5			
	Sta Regist		31. Date filed (Month, Day, Year)	100	trar's Signa	ture on	ule								

			For Stata Registrar	State of I	Maryland / D		artment of H				giene Reg. No.	/ 11111	5 07	452
			Decedent's Name (First, Middle	, Last)						2. Date of De	ath		3. Time o	f Death
	Physicia /Medic		Jane Merwin Br	awner						Month Feb 14	Day 20		2:49	A M
	Examin		4a. Facility Name (If not institution,	, give street and number	er)		4b. City, Town, or	r Location o	of Death		4c.	County of Dea	ath	
			Summerville Ass			15 da	Potomac If Under 1 Year		24 Hrs	0 Data of Dia		ntgome		
	Funeral Director		5. Social Security Number 223–38–0989	6. Sex 7. 1 ☐ M 2 ☒ F	Age (In yrs. last birt	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Date 01/11/		0	rthplace (State country)	
	ס		Usual Residence of Decedent							01/11/	1721	wasi	nington	
	anylan show	_	10a. State 10b. County		10c. City, Towr		cation						10d. Inside C	ity Limits 2 ☑ No
	be Mark	ecto	Maryland Montgo	omery	Potoma	С	101 71- 0-1-				40- 00			24110
	with t	Funeral Director	10e. Street and Number 11215 Seven Loc	lea Dond #20	10		10f. Zip Code 20854				_	zen of What C	ountry?	
	death ms 23	era	11. Marital Status	12. Was Decede	ent Ever in U.S.	13.	Was Decedent of H f Yes, specify Cuba	ispanic Ori	gin? (Spe	city Yes or No		14. Race - Am		
9	after or Ite		1 ☐ Never Married 2 【X Marri	Armed Force ed 1 Tes 2 If Yes, Give			fYes, specify Cuba 1 □ Yes 21☑ No	an, Mexicar Specify:		Rican, etc.)	}	Black, Wh		
903	72 hours after death with the Maryland neturel; or Items 23a or 28a-f show diest Evaniner must be notified at	d by	3 Widowed 4 Divorced	Year or Date								Specify: W		<u>-</u>
21215-0036	J within 72 hours after death with the Marylan item. Itan." Insturel; or Items 23a or 28a-1 show It a Madical Evertinet must be notified at	Completed	15. Decedent (Specify only highes	t grade completed)		(Give	tent's Usual Occup kind of work done of OO NOT use retired	ation <i>during m</i> os d)	t of worki	ng	16b. Kii	nd of Busines:	s/Industry	
12	l within iene. r than "	omp	Elementary/Secondary (0-12)	College (1-4			sh Secre				Ch	urch		
B	e filed il Hyg othe vent,	BeC	17. Father's Name (First, Middle, I	Last)					er's Name	(First, Middle,	Maiden	Sumame)		
ylaı	should be nd Menta marked imatic ev	To	Henry Chester	Merwin				E	ve1yı	Point	en			
Maryland	2 sho		19a. Informant's Name/Relationsh				ng Addrass (Street				•			20051
e,	1 and Health em 27 ther t		Edgar N. Brawne 20a. Method of Disposition	r, Jr. Hu	sband 112		Seven Lo	cks F		308, Po		ac, Mar cation - City o		20854
nor	ages int of t: If it		1 Burial 2 X Cremation 4 Donation 5 Other (Sp		ate cemeter	у, сгег	natory or other plac		\0 /1 7	/2005		•		1
altimore,	permit Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic ence.		21. Signatu of Fu er lifury e l		FL. LL	22	In Cremat . Name and Addre	ss of Facilit)2/1/ ^{ly} Sim	/2005 ple Tr	brei	itwood,	Maryla	.na
ä	permi Depar Impor any ir			can Wear		10	040 Rockv	ille	Pike	, Rocky	$vill\epsilon$, Mary	1and 20	852
	*		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death. Do r	not ent	er the mode of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approxima Interval Be	tween
W	Physician		Immediate Cause (Final disease or condition	a Renal	Failure,	Ac	ute and C	hroni	Lc				Onset and	
	/Medical Examiner		resulting in death)		as a consequence	of):								
		- O	Sequentially list conditions, if any, leading to immediate		ension as a consequence o	of):							5 year	S
	uted d ansit	Examiner	Gagueritian, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	be executed sician and burial-transit		resulting in death) Last	Due to (or	as a consequence	of):								
8760,	ate hy:	dlcal		d			·							
9	eath certific attending pl	0 1	IF FEMALE:	23c. If yes, outco	mo of programmy									
Вох	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death		Ectopic pregnancy Other (specify)	1			2	23d. Date of de Month		Year
o.	at the de by the a tached	hysi	1 □ Yes 2 🔯 No 9 □ Unknown	9□ Unknow			,,,							
s, P	es that igned to be det	by P	Part II. Other significant condition	ons contributing to deat	h but not resulting in	the u	nderlying cause giv	en in Part I.		23e. Did t	obacco u	se contribute	to the cause of	death?
ord	v require been si should b									10	Yes 2	QNo 3□F	robably 4 🗆	Unknown
Records,	e faw rec has bee je 2 shor	ompleted								24a. Was autop	DSV	24b. Were a prior to death?	utopsy findings completion of c	available cause of
a F		0								perfo 1 ☐ Yes			s 2□No	
Vital	9 6 E	o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \times No	Hoenital:	atient 2 ☐ ER/Ou	tnation	t 30 DOA Oth			(Check only only only only only only only only		MASS 1S	tel Liv	ring
10		-	27. Manner of Death	28a. Date of	njury 28b. T	ime of		y at		28d. Describe			outy)	
ior	Attending Ir death. sctor: After	atio	1 X Natural 5 ☐ Pending	gation	July 700.7	ijury		Yes 2	No					
Division		Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inad 286. Flace of	Injury - At home, fa , etc. (Specify)	rm, str	eet, factory, office		1	28f. Location (, City or To			Tural Route Nun	nber,
	id in it		29a. Certifier 1 X Cartifyin	g Physician: To the be	est of my knowledge	deati	occurred at the tin	no date an	d place a	and due to the	canco(c)	and manner	e etated	
	To the Hos within 24 ho To the Fund completely f	edical		Examinar: On the basi and manner	s of examination and									5)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	×17	max		29c. Licens	e number			29d. Date	e signed (Mor	th, Day, Year)	
	6		/ har	XXV	NIND		D0468	6]	Febru	ary 15	, 2005	
			30. Name and address of person		of death (Item 23a) (Lsconsin			Char	737 Ch	aco M.	27.17	and 200	15	
	Sta	te	Robert F. Dyer 31. Date filed (Month, Day, Year)	32. Beg	istrar's Signature			onev	y CII	ase, H	лгуда	111U 200	1.0	
	Regist		FEB 18	2005	we H.	60	will							

		•	1 - State Registrar		Ce	rtificate of	Death		Reg. No.)) = (771 6
	Dhysisi		1. Decedent's Name (First, Middle, Last					2. Date of De Month	Day	Yeer	Time of Death
٠	Physici /Medic		Edward Wi	lliam Be	erryman				ary 16,		6:30 p 1
	Examin		4a. Facility Name (If not institution, give	street and number)			or Location of Death		4c. County		
			4003 Dana Court			_	stead			arroll	
ı	Funeral Director		216-10-4382	x 7. Ag XM 2□F	e (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb 8,	1910	9. Birthplace Country) Maryla	e (State or Foreig and
	pur M	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d	Inside City Limits
	sho	7	,	1.1		3041011	Hamps	tead			1 ☐ Yes 21⁄2 No
	he N	Director	Maryland Carro	<u>L</u>		10f. Zip Code			10g. Citizen of W		
	with I		4003 Dana Court			101. Zip Code	21074		-	JSA	ŗ
	s 23	era		12. Was Decedent	Ever in II S 13	Was Decedont of h		acifu Vae or No		- American	Indian
	hours after death with the Maryland turel; or Items 23a or 28e-f show al Expressional bearedlified at	Funeral	11. Marital Status 1 ☐ Never Married 2☑ Married	Armed Forces?		If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black	k, White, etc.	
36	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	wii	1 ☐ Yes 2 🙀 No	Specity:		Specify:	whi	te
215-0036	2 hou	pa	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu	siness/Indus	try
212	within 72 ene. then "nat	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5	life.	DO NOT use retire		ng	_		
212	d with	E	11	College (1-40) S	Tr	ansit Dr	iver		Tran	sit Co	mpany
Maryland 21	be filed tal Hygir d other event, II	Bec	17. Father's Name (First, Middle, Last)	-			18. Mother's Name	(First, Middle	, Maiden Sumame	e)	
<u>a</u>	uld be dental rked c	To E	Joseph Berryman				Bertha	a Myers			
ary	should and Men s marke umatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Numb	er, City or Town,	State, Zip Co	de)
	1 and 2 Health a em 27 is		Martha E. Berryma	an, wife	4003	B Dana Co	urt, Hamps	stead,	MD 21074		
e,	es 1 a of He of He fitem		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or Town,	, State
Ë	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify)			Crematio		3/2005	Hampst	ead, M	1D
Baltimore,	그 문문을 .		21. Signature of Funeral Service Licens	MO(723 2	2. Name and Addre	ess of Facility	Eline F	uneral H	ome	
m	permi Depa Impo any ir		* Stever	$U \subset J$	mi	934 Sout	h Main St				
			23a. Part1. Ent if the disease, or comp shock, or heart failure. List only	lications tha caused	I the death. Do not en					Ap	proximate terval Between
	Physician		Immediate Cause (Final disease or condition	4	Hung	a solver	T.G.	1			nset and Death
	/Medical		resulting in death)	a / Due to (or as	a consequence of):	aveci	n Tare	144			reced
	Examiner			Caror	are A	ndery	Disease	2		2	O year
		Der	sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of)!						-
	cuted	Examiner	that initiated events	c							
O,	an ar		resulting in death) Last	Due to (or as	a consequence of):						
68760	ite be iysici ne bu	ical		d							
	eath certificate be executed attending physician and for use as the burial-transit	Medical	IF FEMALE:								
XOX	th ce tendii r use		23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		∃Ectopic pregnanc	У			e of delivery	Your
. B	ed fo	sici	in the past 12 months?	4☐ Pregnant at 9☐ Unknown		Other (specify)			Mon	ith Day	y Year
<u>о</u> .	The law requires that the death ce tte has been signed by the attendi bage 2 should be detached for use	Physician	9 Unknown					00 014		4	
	w requires that s been signed t should be det		Part II. Other significant conditions co	d niseb of death o	ut not resulting in the t	inderrying cause giv	ven in Paπ i.		tobacco use contri	3 Probably	
Records,	equii	ompleted by	(Type and is ton	, paper	uguen	un			Yes 2 □ No	3 E FIODADIY	y 4 ∐Unknowi
ec	law ras be	ple						24a. Was	psy p		findings available
		Соп						perfo		eath? ☐ Yes 2☐] No
Viita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only	опа)		
	Q .0	2	1 ☐ Yes 2 ☐ No	Hospital: 1 🗌 Inpatie	ent 2 ER/Outpatie	nt 3 DOA	ner: 4 ☐ Nursing Ho	me 5 esi	dence 6 Othe	r (Specify)	
0	ding PI h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o	f 28c. Inju Wo	ry at rk?	28d. Describe	how injury occurre	∍d	
000	Attending ir death.	atle	2 Accident investigation			M 1	Yes 2□No				
Division of	l or Attenc after death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury · At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (City or To:	Street and Numbe wn, State)	ir or Rural Ro	oute Number,
	rel D			1							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exam	iner: On the basis o	of my knowledge, deat f examination and/or in						
	the hin 2.	Medi	one)	and manner sta	ated.		<u> </u>				
	To the within To the comple		29b. Signature and title of certifier	11/1/		29c. Licens			29d. Date signed		
F	WITL A		1, coper	111 / Car	V, MO	11/3/34	47-98		2-17	1-6	00,0

DHMH 17 Rev 1/2001

State Registrar

ODIGINAL

HO Makalm Etrar's Signature rue Se C Westminster, MD 21157

			Please	State of Ma					-	•	•
			For State Registrar	State of Ma	ii yianu /	•	tificate of			g. N2 0 0 5	071.51
			Decedent's Name (First, Middle, Las	t)	-				2. Date of Death	1	3. Time of Death
	Physicia		Elizabeth Ann Br	ooks					Februar	y 15 200!	5 0230 M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town,	or Location of Deat	n	4c. County of De	eath
			528 Old Westminst	er Pike				inster		Carro	11
	Funeral		Social Security Number 6. Security Number	ex 7. Age □M 2 DXF	(In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Sept 16	9. E	Sirthplace (State or Foreign Country)
	Director		214-28-0743 Usual Residence of Decedent		65	713.			sept 16	1939	W VA
	yland		10a. State 10b. County		10c. City, To						10d. Inside City Limits
	e Mar	ctor	MD Carro	11	Wes	stmi	nster				1 ☐ Yes 2 ☐ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?
	s 23a	sral	528 Old Westminst	er Pike 12. Was Decedent E	ivor in LLS	12.1		1157	nacifu Vac er No	USA	nerican Indian,
	iter de	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		13.	f Yes, specify Cul	Hispanic Origin? (S pan, Mexican, Puerl	o Rican, etc.)	Bfack, Wi	nite, etc.
250	al', or	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🕱 No	Specify:		Specify:	White
0500-CI	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Items 23a or 28a-f show event, the Marical Evanition must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16	a. Deced	dent's Usual Occu	pation during most of wo	rking	6b. Kind of Busines	ss/Industry
7	vithin ne. han "	mpi	Elementary/Secondary (0-12)	College (1-4or 5		life.	DO NOT use retire	ed)		D m mili	Le Company
N	Hygie Hygie ther t		12 17. Father's Name (First, Middle, Last)			.T.	itle Abs		ne (First, Middle, M		re company
yland	ld be ental ked o ic eve	To Be	William Miller						e Summers		
ary	12 should be filed within n and Mental Hygiene. 7 is marked other than "raumatic event, the Me.	-	19a. Informant's Name/Relationship (7	ype, Print)	19					City or Town, State	
Ma,	and 2 valth a 27 ls er tra		Mary White/daught	er		1213	3 Jo Apt	er Pl Ne	w Windsor	, MD 21	776
o c	of He of He if item		20a. Method of Disposition 1 ☐ Buriaf 2 XCremation 3 ☐	Removal from State	20b. Place cemet	of Dispo e <i>ry, crer</i>	sition (Name of natory or other pla	ace) 2/1	9 72 005 2	20c. Location - City	
baitimor	Pag tment tant;		' 4 ☐ Donation 5 ☐ Other (Specify	')	Carro		Cremation			Hampstea	
a n	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evone.		21. Signature of Funeral Service Licen	See						apel, P.A.	
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused	the death. Do	not ent	l2 Washi erthe mode of dy	ngton Roa ing, such as cardia	d Westmi	nster, M	Approximate
	Physician		Immediate Cause (Finaf	one cause on each lin	17 1						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a	consequence		CA				
	Examiner		Sequentially list conditions	b							
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	e of):					
	xecuti and	хап	that initiated events resulting in death) Last	c Due to (or as a	consequence	e of):					
, 60,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	calE	· ·	d							
QQ	ifficate g phy as the			<u> </u>							
X Q	th cert lendin r use	an/N	23b. was decedent pregnant	23c. If yes, outcome of		th 3[Ectopic pregnanc	ev .		23d. Date of c	,
	e dea the att	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown			Other (specify)			Month	Day Year
ī.	hat th od by detach		Part II. Other significant conditions of	ontributing to death bu	ut not resulting	in the u	nderlying cause o	ven in Part I.	23e, Did tob	acco use contribute	to the cause of death?
cords,	requires that the death certificat een signed by the attending phy nould be detached for use as th	d by	. <u>-</u>	3		,	, 3 3		1 ☐ Ye	. /	Probably 4 Unknown
S	sician: The law requ certificate has been rector, page 2 shoul	ompleted							24a. Was an		autopsy findings available
Y Y	The la	omp							autopsy perform	ed? death	o compfetion of cause of ? es 2 \sum No
Vital	ian: 'rtifica	Be C	25. Was case referred to medical					26. Place of Dea	ath (Check only one		20110
OI <	hysic his ce I direc	ToE	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/C	Outpatier	t 3 DOA	her: 4 Nursing h	lome 5 Resider	nce 6 Other (Sp	pecify)
	ing P	lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b	. Time of Infury	Wo	ork?	28d. Describe how	w injury occurred	
UIVISION	death death ctor:) the f	Icat	2 Accident investigation 3 Suicide 6 Could not be		rv - At home	farm str		Yes 2 No	28f. Location (Str.	eet and Number or	Rural Route Number.
<u>≥</u>	after after Direct	Certification:	4 Homicide determined	building, etc	. (Specify)	14111, 30	oot, ractory, onioc		City or Town,		1000110001
	pspite hours uneral		29a. Certifier 1 Certifying Ph	ysician: To the best of	f my knowled	ge, deatl	occurred at the	ime, date and place	, and due to the ca	use(s) and manner	as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ledical	one)	niner: On the basis of and manner sta	examination a ted.	and/or in					``
	with To Con	Σ	29b. Signature and title of certifier	1	_		29c. Licen	se number	29	d. Date signed (Mo	ntn, Day, Year)
	NIL		powerd I		1 ,D.	\ (T:	Point)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	`	2//3	
	3		30. Name and address of person who	on pieteo cause of de	Saun (Item 23a	H) (Type,	Conter	Stract 1	12074 1115	2/15 Ser, H)	81157
¥.	Sta	te	31. Date filed (Month, Day, Year)		r's Signature			William (LOWINING	J. 1.1	-,,,,
	Registr	ar	FEB 15	2005 Elen	we l	K.	South !				

		1 - For State Registrar	State of Maryland		artment of Health and Mattificate of Death	lental Hy	giene Reg. No. 2	005	071,55
ý.		Decedent's Name (First, Middle, Last)			2. Date of De		000	3. Time of Death
Physic	ian				Desides	Month	Day	Year	
/Medi	cal	Richard	Elwood		Bowins	Februa		2005	11:35 PM
Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Death		4c. Cou	nty of Death	
		Frederick Memoria	al Hospital		Frederick		Fr	rederic	:k
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bit (Month, Da	iv Year)	9. Birthpl	ace (State or Foreign try)
Director		218-30-9623	68	Yrs.		APRIL 2	13,193	6 FREL	SERICK, MS.
p.		Usual Residence of Decedent							
how		10a. State 10b. County	10c. City, 7		, 1			11	Od. Inside City Limits
Ma Me-f-	얁	MO. FREDER	CICK FRO	50E4	21CPV				1 Pres 2 No
ت 28 128	<u>ie</u>	10e. Street and Number			10f. Zip Code		10g. Citizen	of What Coun	try?
is Z IZ IS-0050 filed within 72 hours after death with the Maryland Hyglene. Wher than "neturel", or items 23a or 28e-f show ent, the Medical Examiner must be notified at	by Funeral Director	1621 COLONIAL	WAY		21702		4	. S. A.	
death	ere	11. Marital Status	12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto	ecify Yes or No		ace - America	an Indian,
fter trite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No	1:	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	8	llack, White, e	etc.
urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No Specify:		Spe	city: SLA	CK
P of single	ed	15. Decedent's Edu	cation	16a. Decec	lent's Usual Occupation		16b. Kind of	Business/Ind	ustry
in 72	Completed	(Specify only highest grad	e completed)	(Give	kind of work done during most of work OO NOT use retired)	ing	UNITH	D STA	TCS
within than	Ē	Elementary/Secondary (0-12)	College (1-4or 5+) 3 (R5.		CHIEF -INSPECTOR		AIR F		
be filed with tal Hygiene d other tha	ပိ	17. Father's Name (First, Middle, Last)	3.170.		18. Mother's Name	(First Middle			
be de de de de de de de de de de de de de	To Be		BOWINS JI	Q.	Amand			,	
iar yiaritd ZIZIS-0030 2 should be filed within 72 hours after death with the Marylar and Mental Hyglene. Is marked other than "neturel", or items 23a or 28e-1 show eumetic event, the Medical Examinar must be matified at	P								
and and is my		19a. Informant's Name/Relationship (T)	pe, Print) Spacese		g Address (Street and Number or Run				
2 2 m 2 2 2		GOLDIE BOWI			COLONIAL WA	1.1-RE	BERICK	mo.	21702
as 1 as of Hear Item	1	20a. Method of Disposition	20b. Plac	e of Dispo-	sition (Name of natory or other place)	ate	20c. Locatio	n - City or To	wn, State
Dallimor bermit. Pages Department of I mportent: If It my injury or o	1	1 PBurial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	Removal from State	RTON	SVILLE CEM. Feb.	17,2005	FRED.	MD.	
Definit. Pa Departmen Importent: any injury		21. Signature of Funeral Service Licens			. Name and Address of Facility				ac Hone
parmit. Pages Department of I Importent: If Ite any injury or of	1	Maxe J. Kon	leni		OW. SOUTH ST.				
		23a. Part1. Enter the disease, or comp	ications that caused the death						Approximate
		shock, or heart failure. List only o	ne cause on each line	DO NOT BUT	Si the mode of dying, such as cardiac t	X	1		Interval Between
Physician		Immediate Cause (Final disease or condition	· Chr	me	Opsmitte	Julie	rang [hug .	Onset and Death
/Medical		resulting in death)	Due to (or as a consequer	nce of):			1	CITY TO STATE OF THE STATE OF T	0
Examiner		Conventially (interpolations							
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a noneeque:	ioa uf):					
uted d ansit	Ē	Cause (Disease or injury that initiated events							
exec n an ial-tr	Examiner	resulting in death) Last	Due to (or as a consequen	nce of):					
ate be executed thysicien and the burial-transit	cai		4						
ficate ficate pphysis the									
ox o	₩.	IF FEMALE:	23c. If yes, outcome of pregnancy	v			004	Data of dalica	
ath of ath of ath of atten	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de	ath 3	Ectopic pregnancy		1	Date of delive: Month	ny Day Year
the the	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of deate 9 Unknown	n 5	Other (specify)				
at th d by etacl	Physician/Med					00. 5111			(1, 1, 6
gned ex t	by	Part H Other significant conditions co	ntributing to death but not resulting	ng in the ur	iderlying cause given in Part I.	23e. Did 1	obacco use co		e cause of death?
w requires been signe should be	ed	Colonary a	There are	Tos	<u> </u>	1/2	Yes 2□No	3 Proba	ably 4 Unknown
S be shown	Completed		,			24a. Was	an 24	b. Were autop	sy findings available
he la e ha:	E					auto	rmed?	death?	rpletion of cause of
icate						1 Yes	2 No	1 🗌 Yes	2□ No
VICAT iclen: ' certifica ector, p	Be	25. Was case referred to medical examiner?	fospital:		26. Place of Death				
Physe ral dia	2	TE TES ZE NO	Inpatient 2 LEH	VOutpatien	4 Nursing Ho)
ng F Atter	on	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	Bb. Time of Injury	Work?	28d. Describe	how injury occ	berrus	
tending leath. lor: Afte the fune	ati	2 Accident investigation			M 1 Yes 2 No				
r Att	tifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	ə, farm, stre	eet, factory, office	28f. Location (City or To		mber or Rural	Route Number,
s aft s aft	Certification:					,	,		
pspil hour ner y fille		29a. Certifier 1 Certifying Phy	sician: To the best of my knowle	dge, death	occurred at the time, date and place,	and due to the	cause(s) and	manner as sta	ated.
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Exami one)	ner: On the basis of examination and manner stated.	and/or inv	restigation, in my opinion, death occurr	ed at the time,	date and plac	e, and due to	tne cause(s)
outh omp	Me	29b. Signature and title of certifier			29c. License number		29d. Date sig	ned (Month, D	Day, Year)
>		A Ale			D26516		FEB	13	2005
X		MU 137	ampleted squae of death (h-	7-) (T :				-	
6		30. Namil and address of derson who c	ompleted cause of death (Item 23	a) (Type	ALE FOR MA	D 21	262		
		31. Date filed (Month, Pay, Year)	32. Egistrar's Signatur	117E	TIVE TILED IV	10 21	100		
Sta Regist	ate rar	FEB 18 2	JU5 SZ. Qualitar a digital un		coalls				
TEGISI	TEI			6 5					

				ricast					delible liik					gibie.	
			1 - State Registrar			or ivia	ryian		artment of l		ina mer		leg. No.	005	07456
	Physici /Medic		1. Decedent's Name	(First, Middle, L. M. M. M. M. M. M. M. M. M. M. M. M. M.	ast)	4		BO	DEH	M		Date of Dea Month	Day	Yeer	3. Time of Death
	Examin		4a. Facility Name (If	not institution, g	ive street and i	number)			4b. City, Town,	or Location o	f Death			nty of Death	
			Laurel Re				/In um	last hirthday)	Laurel If Under 1 Year	If Under 2	24 Hrs la	Date of Diet			orge's
	Funeral Director		5. Social Security Nu 358–14–55	11	Sex M 2□F			last birthday) Yrs.	Months Days		Min. 12	Date of Birth Month, Day 2/6/19	08°	Miss	place (State or Foreign ouri
	land ow		Usual Residence of 10a. State	10b. County			10c. Cit	y, Town or Lo	cation			_		1	Od. Inside City Limits
	Mary e-f sh	ţō	MD	Howard			Lat	ırel							1 ☐ Yes 2 No
	th the	Director	10e. Street and Num	ber					10f. Zip Code				10g. Citizen	of What Cour	ntry?
	ath w	<u>e</u> 9	425 Ulster	r Drive	· · ·				20723			U	nited	State	S
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Items 23a or 28e-f show event, the Midfield Examinational Demonstrated at	by Fune	425 Ulsten 11. Marital Status 1 □ Never Marrie 3 З Widowed	ed 2 Married	1 ☐ Ye	Forces? s 2 2 N			Was Decedent of f Yes, specify Cub		gin? (Specify , Puerto Rica	Yes or No- in, etc.)	1	lace - Americ lack, White, c <i>ify</i> : Whi	etc.
15-0036	n 72 hoi "natura	Completed	(Specia	15. Decedent's fy only highest g		d)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	of working		16b. Kind of	Business/In	dustry
2	fited within Hygiene. Ither then	dwo	Elementary/Secon	dary (0-12)	College	(1-4or 5-	+)	Plumbe		,0)			Self-E	mploye	ed
Maryland 2121		To Be C	17. Father's Name (I		st)						r's Name (Fi	rst, Middle,	Maiden Sum		
ary	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Na	me/Relationship	(Type, Print)			19b. Mailir	ng Addrass (Stree	t and Numbe	r or Rural Ro	ute Numbe	r, City or Tox	vn, State, Zip	Code)
_	and lealth m 27 her tr		Pat Kull		ter		20h B		Ulster I		Laure		2072 20c. Locatio		
פֿב	0 0			Cremation 3		m State	BOX.	emetery, crer	sition (Name of natory or other pla	Dk (1 1				, Florida
Baltimore,	permit. Pag Department Important: i any njury o		4 □ Donation 21. Signature of Fur			15		22	Name and Addr.	ess of Facility	, flarry	H. W	itzke'	s Fam:	ily F.H.Inc
	NA P		23a. Part1. Enter th shock, or hear	e disease, or co t failure. List oni	mplications that y one cause of	it caused n each lin	the death		er the mode of dy	ing, such as	cardiac or re	spiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (F disease or condition resulting in death)	Final 1	_a	SE	PS	15							Onset and Death
	/Medical Examiner			1	Due	to (or as a	conseq	uence of):	MITE	TI	1971				1 days
	be sit	iner	Sequentially list con any, bading cause. Enter Under Cause (Disease or in that initiated events	ditions, rediate tying	b. Our	o loras a	consage W	of):	7-00	1) 11-	TU	1		_	TURAC
Ć.	ate be executed nysician and he burial-transit	Examiner	that initiated events resulting in death) L	ast	c. Due	lo (or as a	consequ	uence of):		200	611	2/			To cont
68760	cate be physicia the bur	dlcal			d. 14	NS	7 H	1/0	nyp	47	70 J.	ny			10 9EA12
.O. Box 6	The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?		e birth :	2 ☐ Feta	death 3[Ectopic pregnance Other (specify)	;у				Date of delive	ory Day Year
<u> </u>	w requires that the di been signed by the should be detached	d by Ph	Part II. Other signific	cent conditions	contributing to	death by	not resi	ulting in the u	nderlying cause gi	ven in Part I.		23e. Did to	1-1		ne cause of death?
Records,	e law req has been ge 2 shoul	Completed	87SSEM1	NATE	D 1117	TAU	ASC	EXAR	_CEAUX	XATT	on.	24a. Was a autop:	SV		psy findings available mpletion of cause of
_	ysicien: The is certificate hi director, page		25. Was case referre	ed to medical						26 Place	of Death (C/	1 Yes	€ No	1 🗆 Yes	2 No
	ysicle s cert direct	To Be	examiner?		Hospital:	Inpatier	nt 2 🗆	ER/Outpatier	t 3 DOA Ot	hor			ence 6 🗆 C	Other (Specif	y)
Division of	는 는 교		27. Manner of Death 1 Natural Accident	5 Pending investigati	28a. a	te of Injur	y	28b. Time of Injury	Wo		28d.		ow injury occ		
Divis	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	3 Suicide 4 Homicide	6 Could not determine	d 286. Pla	ice of Inju ilding, etc			eet, factory, office			Location (S City or Tow		mber or Rura	i Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical			eminer: On the		examina		n occurred at the t vestigation, in my						
ı	To t To t	Σ	29b. Signature and I	into of certifier	SU	1	M)	29c. Licen	se number	252	2	29d. Date sign	ned (Month,	Day, Year)
)ai	2		30. Name and addre	ess of person wh	VETT	Puse of de	eath (Item	23a) (Type,	Print)	xlaf	t 122	Bow	(EM)	20;	715
	Sta Registr		31. Date filed (Mont		2005	. Pigistra	r's Signa	ture /	house	-,-					

			For State Registrar	State of Ma	ırylanı	-	artment rtificate			nd Ment		ene . No 2 0 A 5	071.57
	Physici		1. Decedent's Name (First, Middle, Las	B1+1	er					_ M	ate of Death onth	Day Year	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give	Hospita		enter ast birthday) 8 Yrs.	If Under 1	5te	ocation of I	Death Hrs. 8 Da	ate of Birth fonth, Day,	4c. County of Dear	<u> </u>
	ס		Usual Residence of Decedent 10a. State 10b. County			, Town or Lo	cation						10d. Inside City Limits
	e Maryl 3a-f sho	ctor	MD Kent			Cheste	rtown			1	-		1 ☐ Yes 2X No
	with th	i Dire	10e. Street and Number 25749 Collins Ave	9			10f. Zip C	ode 2162	20		10g	g. Citizen of What Co CΔ	untry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, Itie Musical Extendion or not be mailified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:			Was Decede if Yes, specif	nt of Hisp Cuban,		n? (Specify Y Puerto Rican		14. Race - Ame Black, Whit Specify: Whi	e, etc.
21215-0036	filed within 72 ho Hygiene. Sther than "natura ent, I to Mad call	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)		+)	(Give life.	dent's Usual kind of work DO NOT use	done dui retired)	ring most o	of working	16	Heating &	•
and 2	2 should be filed void and Mental Hygie is marked other traumatic event, III.	To Be Co	17. Father's Name (First, Middle, Last) Edward Butler						8. Mother's	s Name <i>(Fir</i> s Len Mo		uiden Sumame)	
Maryland	2 should and Men is marke	Ĕ	19a. Informant's Name/Relationship (7				•					City or Town, State, 2	
	s 1 and 2 if Health item 27 i		Mary Joan Butler		20b. P	25/49 lace of Dispo	sition (Name	of		Date	-	n, MD 2162 Oc. Location - City or	
altimore,	0 0		1 ☐ Burial 2 ② Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	<i>'</i>)		sapeak	e Cre	natio	on Fel			evensvill	
Ball	permit. Page Department Important: if any injury o		21. Signature of Funeral Service Licen	Velfenbe	in	22	Fellov 130 Sp	Address 75, i	IEIfe Road	nbein , Ches	& Newr tertow	nam Funera n, MD 216	1 Home, P.A
	Prysician /Medical Examiner	ner	23a. Part1. Enter the disease, or configurations, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter th	one cause on each lin	e. to a a consequ	ence of):				on e		,	Approximate Interval Between Onset and Death
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Physician/Medical Examiner	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	c	of pregna	ncy	Ectopic pre	202004				23d. Date of del	ivery
o.	that the deatled by the atter	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown			Other (spe					Month	Day Year
ecords, P.	w requires that been signed t should be deta	by	Part II. Other significant conditions co	ontributing to death bu	ıt not resu	ulting in the u	nderlying car	ise given	in Part I.		3e. Did toba 1 □ Yes	cco use contribute to	/
α		Completed								_	4a. Was an autopsy performe	prior to	topsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be (25. Was case referred to medical examiner?	Hospital:	a: 2 🗆	ER/Outpatier	nt 3 DOA	Other:		f Death (Che		ce 6 □Other (Spe	-:4.1
ion of	ding h. After funei	\vdash	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y	28b. Time o Injury		: Injury a Work? 1 🗆 Ye		28d. D		injury occurred	элу)
Division	al or Attendes safter deatlal Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	iry - At ho :. (Specify	ome, farm, str	eet, factory,	office			ocation (Stre ity or Town,	et and Number or Ru State)	ıral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (ysicien: To the best on niner: On the basis of and manner sta	examinat								
)	To the within To the comp	M	29b. Signature and title of certifier	(5)	•	va()		License r		501		1. Date signed (Mont.	
125-			30. Name and address of person who of		eath (Item	- 1	Print)) s	TE S	CH	STA	2/17/05 Town, M	D
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 7	32. Registra	ar's Signa	1.61	(med						

			ricase	Obeta of Mandau				•	•	
			1 _ For State	State of Marylan				intal Hyglen	e2005	07458
			Registrar		Ce.	rtificate of D		Reg. N	0.	
	Physici	an	Decedent's Name (First, Middle, Las.	A 1		2-1/04			ay Year	3. Time of Death
	/Medic		G19942	Rebecc	-a 1	Jailey	F		2005	1:40a.M
	Examin	er	4a. Facility Name (If not institution, give	1 /		4b. City, Town, of L	. 1	1 4	c. County of Death	,
			Talbot Hos	Pice Hous	0	L-as	If Under 24 Hrs. 8	15:11	Talbot	
	Funeral		5. Social Security Number 6. Se	TH OFFE A	Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Year		lace (State or Foreign
	Director		Usual Residence of Decedent	6)		<i>N</i>	1arch 20, 10	739 Mai	ryland
	/land		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation			1	0d. Inside City Limits
0	Man Fed	to	MD talk	014	ora	lava				1 ☐ Yes 2 ☑ No
$^{\prime}$	r 28g	Director	10e. Street and Number		<u>, , , , , , , , , , , , , , , , , , , </u>	10f. Zip Code		10g. C	itizen of What Coun	itry?
3	death with the Maryland ma 23s or 28s-f show rmtel be notfilled at	O E	11652 010	Condovat	Road	216	2,5		U5 A	9
6	deat ma	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Speci	fy Yes or No-	14. Race - Americ	an fndian,
9	after or Ite		1 ☐ Never Married 2 ☐ Married	1 □ Yes 2 12 No			Specify:	can, etc.)	Black, White,	etc.
8	72 hours after natural', or Ite	d b	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		10165 2210	эрвспу.		Specify: 810	2CK
21215-0036	72 h 'natu	Completed by	15. Decedent's Edi (Specify only highest grad	ication le completed)	(Give	dent's Usual Occupat kind of work done du	ion iring most of working	16b. l	Kind of Business/Ind	dustry
12	within ene. than	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			1-110	1
	e filed within al Hygiene. I other than ' vent, tre Me	ပ္ပ	17. Fathada Nama (First Middle (cas)		1+0	usekee	1		tel/kes	taurant
anc	be fi	Be	17. Father's Name (First, Middle, Last)	A 4 1 1 1 1	1		18. Mother's Name (rirst, middie, maide	n Sumame)	
Ž	d Mean	²	EZeK:el	Mitchel			Dorot	hy FI	etcher	
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Heatth and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show injury or other traumatic event, the Medical Examination that he mailting at 18.	H	19a. Informant's Name/Relationship (T	1	19b. Malli	ng Address (Street ar	od Number or Hurai i	nin	or Iown, State, Zip	0 1 6
-	1 and Healt Nm 2 ther		20a. Method of Disposition	andener	lace of Dispo	sition (Name of	Lordova	Kd, Co	ocation - Oily or To	D. 21625
و	Pages nent of int: If it		1 Ø Burial 2 ☐ Cremation 3 ☐ I	Removal from State	emetery, crei	natory or other place,	2/10		/	
Baltimore	it. P.		4 □ Donation 5 □ Other (Specify,21. Signature of Funeral Service Licens		apel	CPMe terk! Name and Address	1	100 20	astow, N	lakyland
Ba	permit. Pages Department of I important: If ite any injury or of		A: AA O O O	Or Donne	1	tenry Fi	ineral	Home, Cil	4-1	0 01/12
			23a. Parti. Foter the disease, or comp	lications that caused the deat	Do not ent	er the mode of dving	ING TON S	to Cambi	Ridge/VII	Approximate
			23a. Parv. Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final	ne cause on each line.				oophatory arrost,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Dn	Cavei	noma			1 1/2 years
.5%	Examiner			Due to (or as a consequ	ience of):					,
	MAC THE	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	Jence of):					
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć,	tificate be executed Ig physician and as the burial-transit	Еха	resulting in death) Last	Due to (or as a consequ	uence of):					
760,	re be ysicia e bur	cal		d						
89	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	led								
Box	h cer endir use	2	230. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregnancy			23d. Date of delive	ry
	deat	Sicie	in the past 12 months? 1 ☐ Yes 2 🕱 No	4 Pregnant at time of de		Other (specify)			Month	Day Year
P.0.	w requires that the death been signed by the atte should be detached for	by Physician/Med	9 🗆 Unknowh							
	es th gned be de	by	Part II. Other significant conditions co	ntributing to death but not resu	ilting in the u	nderlying cause given	in Part I.		use contribute to th	e cause of death?
bro	equir en s	ted						1 ☐ Yes 2	2∯No 3∏Proba	abiy 4 ∐Unknown
Records,	law r as be 2 sh	pie						24a. Was an autopsy	24b. Were autop	osy findings available
<u>ш</u>	The ate h page	Completed						performed? 1 ☐ Yes 2 🔀 No	death?	
Vital	icien: The lav certificate has rector, page 2	Be (25. Was case referred to medical examiner?				26. Place of Death (Check only one)		
<u>></u>	hysin his o	ပ	1 ☐ Yes 2 🐧 No	dospital: 1 Inpatient 2 I	ER/Outpatien		4 Nuising Home	5 🗌 Residence	6 Other (Specify	House
n	ng P	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	at 28	d. Describe how inju	iry occurred	
sio	death death stor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				es 2 No			
Division of	i or At after d Direct I in by	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	28	Location (Street a. City or Town, Stat	<i>nd Nu</i> mber or <i>Rural</i> e)	Route Number,
	urs a arai C						1			
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medicai	29a. Certifier 1⊠ Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the time vestigation, in my opir	, date and place, and nion, death occurred	d due to the cause(s at the time, date an	s) and manner as sta od place, and due to	ated. the cause(s)
	o the ithin o the omple	Mec	29b. Signature and title of certifier	and marrier stated.		29c. License	number	29d. Da	ate signed (Month, E	Dav. Year)
)	⊢ ≯ ⊢ δ		Mant 11	150000	10-0	1	17777	17	1 ,	2005
			30. Name and address of person who ca	ompleted cause of death (Itom	23a) (Tune	Print)	11232		413/2	(00)
			De Marie C Dochi	elde 500 tale	- 5 Line	Arro Engl	on MD 27	601		
	Sta	e	Dr. Mary S. DeShi 31. Date filed (Month, Day, Year)	32. Registrar's Signat	INTIG Y	ave. Last	on, MD 21	OOT		
	Registr	19.0	FEB 17	32. Registrar's Signat	18	losel.				
DH	MH 17 Rev 1/20	01		A STATE OF THE PARTY OF THE PAR	19	1				

			1 - For State Registrar	State of Mary		epartme Certifica				giene	05	07450
	Dhysis		1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medi		OSCAR ARNOI		₹				FEBRUA		2005	01:21A M
	Examir	ner	4a. Facility Name (If not institution, gi			4b. Cit	y, Town, o	r Location of Death		4c. Coun	ty of Death	
Jr.			VA MARYLAND HEALS 5. Social Security Number 6.				RRY I	POINT If Under 24 Hrs.	10.0	CECI		
	Funeral Director		212–28–4834	1X M 2 F	n yrs. last birth 76 Y	rs. Months		Hours Min.	8. Date of Birth (Month, Day Dec 26,	7, Year) 1928	Cou	
ori 	9		Usual Residence of Decedent						DCC 207	1,720	Mal	yland
Bishop	show	<u>_</u>	10a. State 10b. County		c. City, Town	or Location						10d. Inside City Limits
	Be-1:	Director	Maryland Harf	ford				Aberdeen				1 ☐ Yes 2X No
Arnold	death with the Maryland ms 23a or 28e-1 show In ust be notified at	Dir	10e. Street and Number 601 Cornel 1	l Street, Apt	- 407	10f. 2	ip Code	21001		10g. Citizen o	f What Cou SA	ntry?
Arı	death ms 23	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?		13. Was Dec	edent of H		ecify Yes or No-		ace - Americ	can Indian
6 E	after or ite	Fur	1 ☐ Never Married 2 🔀 Married	1 X Yes 2 ☐ No				lispanic Origin? (Span, Mexican, Puerto	Rican, etc.)		ack, White,	etc.
Oscar -0036	irel',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 19!	51–53	1 LI Yes	2 X No	Specify:		Spec	ity: Bla	ack
0.5	within 72 hours after ene. then "neturel", or Ite re Mazileal Examiline	Completed	15. Decedent's E (Specify only highest gr	iducation rade completed)	16a. [Decedent's Us	ual Occup vork done	ation during most of work d)	ing	16b. Kind of	Business/In	dustry
AN:	withir ene. then	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		Truck				Colf	Emple:	
PHYSICIAN aryland 212	illed Hygid other	BeC	17. Father's Name (First, Middle, Las	t)		ILUCK	DIIVE	18. Mother's Name	(First, Middle,	Self Maiden Suma		yea
YSI Ian	ould be Mental tarked o	To B	Oscar Jerome Bis	shop				Sarah	Bond			
Delivation Oscar Maryland 21215-0036	Sh man		19a. Informant's Name/Relationship					and Number or Rura				
	permit. Pages 1 and 2 Department of Health a Importent: If item 27 th eny injury or other tre ance.		Monica Thomas / d									ginia 23464
<u>_</u>	Pages 1 nent of H nnt: If ite iny or ott		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 [, crematory or	other plac	(e)	Date	20c. Location	- City or To	own, State
KNOWN	t. Pa rtmen rtent: njury		`4 □Donation 5 □Other (Special		R.A. I	Ferris			2/05	West (Cheste	er, PA
Bal	permit. Departr Importe eny inji		21. Signature of Funeral Service Lice	nsee				ss of Facility ott Funera	l Home,	P.A.		
NAME	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the yone cause on each line. CONGESTIV		ot enter the mo	ode of dyin	ott Funera s Street, g, such as cardiac o	Havre or respiratory arr	de Gra		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co								JNKNOWN
. 0		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):						
X	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c								
`°,	oe execian a	EX	resulting in death) Last	Due to (or as a con	nsequence of):						
98760	ate hy:	dical		d					_		-	
9 x	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE:	23c. If yes, outcome of pr	regnancy					224 D	ata of daling	
Вох	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death	3 ☐Ectopic (ate of delive lonth	Day Year
0	at the de by the tached	hysi	9 Unknown	9□ Unknown								
Division of Vital Records, P.O	es that igned to be det	by P	Part II. Other significant conditions	contributing to death but no	ot resulting in t	he underlying	cause give	en in Part I.	23e. Did tol	cacco use cor	ntribute to th	ne cause of death?
ord	w require been sig should t	ted							1 □ Ye	es 2□No	3 🗌 Prob	ably 4 XUnknown
ec	as bu	ompleted							24a. Was a autops	v	prior to cor	psy findings available inpletion of cause of
=======================================		Col							perform 1 Yes 2	ned? 2█ No	death?	2 No
V. it.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 🗴			Otho	26. Place of Death		-		
of	Phys	. To	1 Yes 2 No 27. Manner of Death	1 🕰 Inpatient	2 ER/Outp		OA Injury	ar: 4 ☐ Nursing Hor	ne 5 🗆 Reside 28d. Describe ho)
lon	nding Fith.: After a funer	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	a <i>r)</i> Inji	ury M	28c. Injury Work 1 🔲 \	(? Yes 2 □ No		, w mjary ooda	1100	
V.S.	tel or Attendi s after death. el Director: A ed in by the fu	ertification:	3 Suicide 6 Could not be determined		At home, farm	n, street, facto	ry, office	- 2	28f. Location (St	reet and Num	ber or Rura	I Route Number,
Ö	s afte	Cert	4 - Homiciae	building, etc. (S)	рөспу)				City or Towr	i, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 ★ Certifying Pl 2 ★ Medical Example 1	hysician: To the best of my miner: On the basis of exa and manner stated.	/ knowledge, o mination and/	death occurred or investigatio	d at the tim n, in my op	ne, date and place, a pinion, death occurre	and due to the ca ad at the time, da	ause(s) and m ate and place,	anner as st and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29	c. License	number	25	9d. Date signe	ed (Month, I	Day, Year)
	z l a		1/201	1.			5273	9		FEBRUAI	RY 17,	2005
6	ta, 16		30. Name and address of person who			, , ,						
	Sta		SURESH SHANDELYA, 31. Date filed (Month, Day, Year)	M.D., VA MA		HEALTI	d CAR	E SYSTEM,	PERRY 1	POINT,	MD 21	.902
	Sld Registr	re i	FFR 2 2 2	A	15	and a	•					

			1 - For State of Maryland / Dep	artment of Health and Martificate of Death	Reg	2005 07460
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Bobby Gene Busbice		2. Date of Death Month February	Day Year 17, 2005 1:05 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Prince George's Hospital	Cheverly		Prince George's
	Funeral Director		5. Social Security Number 214-36-9413 6. Sex 7. Age (In yrs. last birthday 75 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y Sept. 6,	9. Birthplace (State or Foreign Country) LA
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or It	ocation		10d. Inside City Limits
	ith the Marylan or 28a-f show	ō	MD Prince George's Lanham			1X Yes 2 No
	r 28a	rec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	th with	al D	6932 Lamont Drive	20706		USA
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I tem 23 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Exerting right by riviliar at	by Funeral Director		Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 WNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
9	hour tural	ed b		edent's Usual Occupation	16	White Sb. Kind of Business/Industry
21215-0036	in 72 n "na	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing	b. Fill of Basillossallossity
212	yiene.	E	Elementary/Secondary (0-12) College (1-4or 5+) 5 Dept.	of Argiculture -	Agent U	niversity of Maryland
	e filec al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Sumame)
/lar	uld by Menta Irked Itic e	To E	Edmond Busbice	Ivie Br	rown	
Maryland	2 sho and I is me		19a. Informant's Name/Relationship (Type, Print)	ling Address (Street and Number or Rura	al Route Number, C	City or Town, State, Zip Code)
	and ealth m 27					on, Maryland 20784
ore	Pages 1 nent of H int: If ite		1 Buriai 2 Ki Cremation 3 Hemoval from State	ematory or other place)		c. Location - City or Town, State
ţ.	tment tant:		`4 □ Donation 5 □ Other (Specify) Metropol			lexandria, Virginia
Baltimore,	permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is any injury or other trau			22. Name and Address of FacilityGas(
	40244		23a. Part Enter the divise, or complications that caused the death. Do not e	4739 Baltimore Aver		
	Physician /Medical Examiner	J	shoot, or heart failure. List only one cause weach line. Immediat Cause (Final disease r condition resulting in death) Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	ed		Interval Between Onset and Death
8760,	The law requires that the death certificate be executed the bas been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or if its y that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
.O. Box 6	that the death certificated by the attending placed by the attending placed for use as t	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	w requires that been signed b should be det		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
I Records,		Completed by			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? 1 No 1 Yes 2 No
Vital	ysician: is certific director,	Be (25. Was case referred to medical examiner?		h (Check only one)	
of \	> .00 0	2	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient			ce 6 Other (Specify)
N C	ding F	lon:	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how	milury occurred
Division	Attender death ector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
	the Hospital or hin 24 hours after the Funeral Dir npletely filled in	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, detailed. Check only one) Certifying Physician: To the best of my knowledge, detailed. Check only one)	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau- red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
)	To th To th comp	Me	29b. Signature and title of certifier	29c. License number D005703		Date signed (Month, Day, Year)
)_	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type Bar bar Ration, M, D, 4404	Pueensbury R	LL, Rive	2/18/05 Idale, MD 20737
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 2 2005			

Amended Item 5 per F.D. 02/23/2005 Carroll County, will Amended Item 5 per F.D. 02/18/2005 Carroll County, will Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07461 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Pay 14, 2005 **Physician** Christian Feliciano Crim 1543 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 37 Old Westminster Pike Westminster Carrol1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Apr 28, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Yrs. Director 06-4260 21 1983 Mexico Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits item 27 is marked other than "natural", or Items 23e or 28a-f show other treumatic event. The Medical Examinar must be notified at 1 ☐ Yes 2 No Director 1637 Old Westminster Pike Westminster Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 1637 Old Westminster Pike Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unemployed N/A 0 **GFD** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fit and Mental H Sandra Falkenstine Harold Crim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1637 Old Westminster Pike, Westminster, MD 21157 Sandra Bauerline Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 0 = 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. 0 2/16/05 Hampstead, MD Carroll Cremation Inc 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licenses | 412 Washington Rd. Westminster, MD 21157 23a. P. n1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Self-Inflicted GSW to head seconds disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): $\sqrt{3}$ ے $\zeta_{\ell} \iota^{\ell} \iota^{\ell} \iota^{\ell} \ell^{\ell}$ Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1 ☐ Yes 2LX No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ို 1 XYes 2 □ No ^{28b. Timeound} 1540hgs 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Feb. 14,2005 1 ☐ Yes 2 ☐ No shot self in head 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number 21157 in by To the Hospital within 24 hours after
To the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Office of the Funeral O 1637 Old Westminster Pike Home 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number D12051924 address son who completed cause of death (Item 23a) (Type, Print) J. MA 14-741 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

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DHMH 16 Rev 6/95

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Day Year 00 AM 2005 Constance a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner County Howard General Columbia HUSPITAI Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, July 5, 1913) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Massachusetts **Funeral** 1 ☐ M 2 🎞 F 91 218-38-8301 Director Usual Residence of Decedent r 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2 € No Director Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be: 3004 North Ridge Road, Apt. H309 20143 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 € No à Specify. 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Health Care othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ith and Mental F 27 Is marked of traumatic avar 8 Alfred Lauzon Arthemise Guav Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a sortant: If Item 27 Is / injury or other trates. William A. Craig, III/ Son 7824 Lonesome Pine Lane, Bethesda, MD 20817 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 7, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2005 Rockville, Maryland 21. Signature of Funeral Service Dicense 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATherosclerot Physician vasular /Medical Examiner Yr. Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ nce of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medicai as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a P.0. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 4 Unknown 3 Probably 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has osteoponosio 2 No 1 ☐ Yes 1 Tyes Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 ER/Outpatient 3 □ DOA After this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide ö within 24 hours at To the Funeral D completely filled i To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 ROCIOIFO Fernandez, M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catonin reder 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

legistrar's Signature

FEB 1 8 2005

			For State Registrar	State of	Maryland / D	epartmei C <i>ertifica</i>			and Me	-	iene 0	05	071	464
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	/Medic	al -	Catherine Ann Con 4a. Facility Name (If not institution,		than)	4h Cin	Town or	Location o		February	4c. Count		6:04	
	Examin	er	Holy Cross Hospit	•	1001)	1 '		Spring				gomer		
-	Funeral			6. Sex	7. Age (In yrs. last birth	day) If Unde	r 1 Year	If Under 2	24 Hrs. 8	. Date of Birth	1	9. Birth	place (State	or Foreign
	Director		213-58-6607	1□M 2 ∑ F	55 Y	rs. Months	Days	Hours	Min.	(Month, Day	1949		ryland	
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	os Location							10d. Inside (City Limits
	shov ed at	j		_	Toc. Oily, Town									s 2 🔼 No
	the N	Director	Maryland Ho 10e. Street and Number	ward		Laurel	p Code				log. Citizen of	What Cou	intry?	
	3a or		9896 Whiskey Run				207	23				USA	,	
	death ma 2:	Funerai	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. Was Deci	dent of H	ispanic Orig	gin? (Speci	fy Yes or No- can, etc.)	14. Ra		ican Indian,	
98	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f show aumatic event, the Medical Exam. Inclination inclination and the modified a		1 Never Married 2X Marri	Armed For ed 1 Tes If Yes, Give	2 X No			n, mexican Specify:				ick, White, fy:White		
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ğ	illed Hygi other	0	17. Father's Name (First, Middle, I	_ast)				18. Mothe	r's Name (First, Middle,	Maiden Sumai	me)		
Maryland 21215-0036	should be and Mental a marked o	ToB	Ulises Consuegra					Ju	lia Ba	ltuska				
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2	and lealth m 27 her tr	Į.	Allen W. Snyder/ H	usband	989 20b. Place of	6 Whiske		Laure	1, MD Dat		20-1	O'1T	Ctata	
Baltimore,	Po it of P		20a. Method of Disposition 1 □ Burial 2 □ Cremation		State cemetery	, crematory or	other plac	1 -	ebruar		20c. Location	- City or 1	own, State	
ij	it. Pa		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Gate of	Heaven 22. Name a			2005		Silver S	pring,	Maryl	and
Ba	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once.		De Cincheil	Q Cole		Francis	J. Co	llins	Funera	l Home I	nc oring, MC	2090.	ı	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	aused the death. Do no								Approximation Interval Bi	etween
	Pnysician		Immediate Cause (Final disease or condition	_aSepcis									Onset and	d Death
	/Medical Examiner		resulting in death)		or as a consequence o):								
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8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cal		d										
9	rtifica ng ph s as th	Medi	IF FEMALE:	_										
Вох	eath certific attending pl	an/M	23b. Was decedent pregnant in the past 12 months?	1 Live bi	come of pregnancy rth 2 Fetal death	3 ☐Ectopic						ate of delive	ery Day	Year
0	at the dea by the a tached f	Physici	1 □ Yes 2 □ No 9 □ Unknown	4∐Pregna 9□Unkno	ant at time of death wn	5 Other (s	pecify)							
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Vital		BeC	25. Was case referred to medical examiner?					26. Place	of Death (Check only or				
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		on:	27. Manner of Death 1 Natural 5 □ Pending		of Injury 28b. Ti h, <i>Day Year)</i> In	ury	28c. Injun Wor	k?		d. Describe h	ow injury occur	rred		
Sio	or: or:	icat	2 Accident investig	ot be	of Injury - At home, fan	M street facto		Yes 2 ☐ î		f Location (S	treet and Num	har or Pur	al Poute Ni	umher
Division	in the	Certification;	4 Homicide determine	ned 200. 1 lado buildir	ng, etc. (Specify)	ii, street, racto	ry, omce		20	City or Tow		567 07 71471	27710010770	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in				best of my knowledge,									
	he Ho in 24 he Fu pletel	edical	(Check only 2 Medical I one)	Examiner: On the ba and mann	usis of examination and her stated.	or investigatio	n, in my o	pinion, deal	th occurred	at the time, o	late and place,	and due to	o the cause	e(s)
	within	2	29b. Signature and title of certifier		(1)	25	c. Licens			2	9d. Date signe	d (Month,	Day, Year)	
•	di		1/ Clupai	ه	1	5	D61	.595					211	7/2005
	10		30. Name and address of person	·	•				745 OC	010				,
E.	Sta	ate.	Marjorie Pennant, 31. Date filed (Month, Day, Year)		Forest Glen			pring,	שב עניין	910				
	Registi		FEB 18	2005	egistrar's Signature	Gorde								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** A DAVIN 2005 Maa /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Legional Nedical If Under 1 Year Months Days ir If Under 24 Hrs.
s Hours Min. 1 Sula WICONICO 7. Age (In yrs. last birthday) Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 201 F Months 215-20-4550 Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Hems 23a or 28a-f ahow any injury or other fraumatic avant. It a Medical Exercities must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21801 U.S. A 54 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BIACK Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 215 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fannie MATTHEW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marshu Bickott - Doughter 3149/ Eden 20c. Location - City or Town, State Allenke 01/800 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 □Removal from State 24/05 Oakstille Ceretin 4 □ Donation /5 □ Other (Specify) al Service Licensee the Furanal Harr W Isabella 5+ 23a. Part1. Enter the disease, or complicated that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 106 ulrnong /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2/12 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 2/2 No Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

ne and address of person who 🥳 leted cause of death (Item 23a) (Type, Print)

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32. Degistrar's Signature

			1 - For State Registrar	tate of Maryland /	Depar <i>Certi</i>	tment of Heal ficate of Dea	th and Me ath		ene () () (07466
	Physici		Decedent's Name (First, Middle, Last)	K. Carter			2	Date of Death Month FEb.	Day 200	3. Time of Death 3. 3.45 M
	/Medic Examin		4a. Facility Name (If not institution, give street			b. City, Town, or Loca	ation of Death	160.	4c. County of De	eath
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last bi			ours Min.	. Date of Birth (Month, Day, 1	9. E 912 M	Birthplace (State or Foreign Country) aryland
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Loca	tion				10d. Inside City Limits
	the Mz	ecto	Maryland Wicomico	Sal	isbu	10f. Zip Code		100	g. Citizen of What	1 Yes 2 XNo
	th with	al Di	219 Potomac Ave.			21804		1	USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importents: If item 27 is marked other than "naturei", or Itame 23a or 28e-f show any injury or other treumatic event, the Medical Exattr art minal te routing an ange.	by Funeral Director	1 ☐ Never Married 2 ☐ Married	Was Decedent Ever in U.S. Armed Forces? 1 I □ Yes 2 M No If Yes, Give Year or Dates:	If Y	is Decedent of Hispan es, specify Cuban, Me Yes 2 No Sp	ic Origin? (Specif exican, Puerto Ric ecify:	y Yes or No- can, etc.)	14. Race - Ar Black, W Specify:	merican Indian, hite, etc. white
21215-0036	within 72 ho lene. than "natur the Medical	Completed	15. Decedent's Educati (Specify only highest grade co Elementary/Secondary (0-12)	mpleted) College (1-4or 5+)	(Give kir	nt's Usual Occupation nd of work done during NOT use retired)	most of working		6b. Kind of Busines Pharmacu	,
	be filed al Hygi d other	Be C	17. Father's Name (First, Middle, Last)	4.			Mother's Name (/	First, Middle, Ma	aiden Sumame)	
Maryland	hould to Ment	ို	George Carter 19a. Informant's Name/Relationship (Type,	Print) 19	h Mailing	Address (Street and N	Sophie I			Zin Code)
	and 2 s laith an 127 is er treu		Helen E. Hollenbach		-	Potomac Ave			MD 21804	, 110 0000/
lore	ges 1 and the control of the control		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remarks	oval from State TT Cemete	of Disposit Pry, crama Redec	ion (Name of tory or other place) EMEL	Date 2 / 22 /		Oc. Location - City	
Baltimore,	permit. Pa Departmer Importent: any injury	ĺ	4 □Donation 5 ☑Other (Specify)En 21. Signature of Funeral Service Licensee	tombment Cemet	ery Ho	lame and Address of I	2/22/ Facility eral Hom	ne Profe	Baltimore essional	Association
	90740	-	23a. Part1. Enter the disease, or complicati	ons that caused the death. Do	1 30	1 200% HIT	I RO., S	allsbur	Y, MD 21	Approximate
	Physician		shock, or heart failure. List only one c Immediate Cause (Final disease or condition	ASCVC)					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):					
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	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):					
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.O. Box 68	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1∐Live birth 2 ∏Fetal deat 4∏Pregnant at time of death 9⊡Unknown		ctopic pregnancy other (specify)			23d. Date of o	delivery Day Year
Δ.	wrequires that the de been signed by the s should be detached	þ	Part II. Dther significant conditions contrib	uting to death but not resulting	in the und	erlying cause given in l	Part I.			to the cause of death? Probably 4 Minknown
I Records,	The law req ate has beer page 2 shou	Completed						24a. Was an autopsy performe	prior t	
Vital	Physicien: this certificated director, i	Be	25. Was case referred to medical examiner?	pital:		Othor	Place of Death (0			
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Division	ei or Attendii s after death. Il Director; Ai id in by the fu	Certification;	a Could not be	8e. Place of Injury - At home, f building, etc. (Specify)	arm, stree	t, factory, office	281	Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	To the Hospitel or Attendit within 24 hours after death. To the Funerel Director; All completely filled in by the fu	edicai C	29a. Certifier 15 Certifying Physicia (Check only one) 2 Medical Exeminer:	en: To the best of my knowledg On the basis of examination a and manner stated.	e, death o	ccurred at the time, da stigation, in my opinion	ate and place, and n, death occurred	d due to the cau at the time, dat	ise(s) and manner e and place, and d	as stated. ue to the cause(s)
.	To the To the comp	ž	29b. Signature and title of certifier			29c. License num			d. Date signed (Mo	nth, Day, Year)
•	03		30 Name	leted cause of death (Item 23a)	O	H005)	710		2/21/05	
	B		51mona Eng 11	TO E. Carroll	SH	HOO5) Salishu	rd m	0 218	201	
	Sta Registr		31. Date filed (Month, Day, Year) FFR 2 2 200	32. Registrar's Signature			7-7			

DHMH 17 Rev 1/2001

Thomas CARTER 213-01-8462

			1 - For State Registrar			lealth and M	ental Hygie	•	07467
	Physici /Medio	al	Decedent's Name (First, Middle, Las Woodland Eug Aa. Facility Name (If not institution, give	gene Cox	Ab City Town o	at Location of Double	2. Date of Death Month FEBRUARY		
	Examin Funeral Director	er	St. Mary's Hos	spital		ardtown If Under 24 Hrs. Hours Min.	8. Date of Birth	St. Mar 9. Bir 3,1946	
	e Maryland 3e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD St. Ma	10c. City, Town or Lo	cation icsvill	e			10d. Inside City Limits 1 ☐ Yes 2 📉 No
9	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heelih and Menail Hygiene. Important: if fier az 1 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Modical Examina in the retilled an once.	by Funeral Director	10e. Street and Number 26066 Crescent 11. Marital Status 1 □ Never Married 2 ★ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No		9 dispanic Origin? (Spean, Mexican, Puerto F		USA 14. Race - Ame Black, Whit	erican Indian, e, etc.
21215-0036	filed within 72 hours Hygiene. ther then "natural", ent, the Medical Exa	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	year or Dates: ucation de completed) 16a. Deced (Give	dent's Usual Occup kind of work done OO NOT use retired chanic		16b	Specify: Kind of Business Auto	white /Industry
Maryland	2 should be filt and Mental Hy is marked oth eumatic event	To Be (17. Father's Name (First, Middle, Last) Gilbert Irving 19a. Informant's Name/Relationship ()		ng Address /Street	18. Mother's Name June A and Number or Rural	rlene W	right	Zin Code)
	ges 1 end 2 s of Heelth ar if item 27 is or other treu		Glenna Cox 20a. Method of Disposition 1 □ Burial 2XC Cremation 3 □	26 0 0 20b. Place of Dispo cemetery, cren	66 Cres sition (Name of natory or other place	cent Lan	e,Mechan	nicsvil Location - City or	le, MD20659 Town, State
Baltimore,	permit. Pages Department of I Important: if its any injury or o		21. Signature of Funeral Service Licen	Brinsfie M00945	AREHAR	ols 2/19 T_ECHOLS	FUNERA	L HOME,	P.A.
	Physician /Medical Examiner pnial-transit	Examiner	23a. Part1. Enter the disease, or composition of the control of th	a. Due to left as a consequence of): b. Due to (or as a consequence of): c.	P.O. Burthe mode of dyir	Herne	respiratory arrest,	A,MD 21 ✓	Approximate Approximate Interval Between Onset and Death
P.O. Box 68760,	death certificate e attending phy: d for use as the	Physician/Medicai Ex	IE EEMAL E		Ectopic pregnancy Other (specify)	,		23d. Date of del Month	ivery Day Year
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WCODLAND EUGENE COX Division of Vital Records, P.O. Box 68760,

Physic	ian	1. Decedent's Name (First, Middle		aryland/Dep a-f per me	ranoato or	Death	2. Date of Death Month	-	3. Time of Dea
/Medi Exami	cal	June Marie 4a. Facility Name (If not institution,	Jones Car	roll	4b. City, Town, o	r Location of Death	Februar		05:09
		200 East Main		tment 4	E1ktor			Ceci	
Funeral Director		5. Social Security Number 219-82-9913 Usual Residence of Decedent	6. Sex 7. Age 1	e (In yrs. last birthday) 43 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y June 22	9. Bi	rthplace (State or For country) CA
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23a or		10e. Street and Number #2 Kent Rd			10f. Zip Code		10g	. Citizen of What C	
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I within 72 ho liene. r than "natur the Medical	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of worki	ng 16	o. Kind of Business	s/Industry
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t. Pages 1 and 2 should be riment of Health and Mental riant: if item 27 is marked o njury or other traumatic eve	Be	17. Father's Name (First, Middle, L				18. Mother's Name	(First, Middle, Ma.	den Sumame)	
	To					Arrants Rural Route Number, City or Town, State, Zip Code)			
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		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from State	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place	(e)	ate 200	. Location - City or	Town, State
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ysicia	icai Examiner	shock, or fleart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Alcohol Due to (or as a b. Due to (or as a	and oxycoca consequence of):	done into	xication			Interval Between Onset and Death
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		1. Decedent's Name (First, Middle, Last)				2. Date of Death	NO. O O O	3. Time of Death
Physician	_	Emerson Lee Cannon			L.		Day Yea 15 200	r
/Medical		la. Facility Name (If not institution, give street and number)		4b. City, Town, or Locat			4c. County of De	
Examiner				Cambrid			Dorche	
E		Chesapeake Woods Center 5. Social Security Number 6. Sex 7. Age (In)	rs. last birthday)			I. Date of Birth		
Funeral Director		212-12-3951 1 M 2 F 92 Usual Residence of Decedent	Yrs.	Months Days Hou	urs Min.	B. Date of Birth (Month, Day, Yes June 9,	1912 M	irthplace (State or Foreigi Country) aryland
Show			City, Town or Lo	cation Cambride	(TO			10d. Inside City Limits 1 Yes 2 □ No
vith the Mar		10e. Street and Number		10f. Zip Code		10g.	Citizen of What	Country?
with w		525 Glenburn Ave.		216			U.S.A	
ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "naturel; or items 23e or 28e-f show or other traumatic event, the Medical Francisco Tribal be invitible at the Completed by Funeral Director.	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes, 2 Widowed of the State of Married in Yes, Give Year or Dates:	i	Was Decedent of Hispanic If Yes, specify Cuban, Mea 1 ☐ Yes 2 ☑ No Spe	ic Origin? (Speci xican, Puerto Ri ecity:	ify Yes or No- can, etc.)	14. Race - Ar Black, WI Specify: W	
ed within 72 hours aft ygiene. her than "naturel", or t, the Medical Examil Completed by F		15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b	. Kind of Busines	ss/Industry
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should be true with the should	2	Charles Goldsborough Cannon			Sallie 1			
2 sho		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Nu				, Zip Code)
C, IV		Beverly Creighton p.r.	b. Place of Dispo	Box 34, Ch	hurch Cr		21622 Location - City	as Taura Chata
Pages 1 nent of H int: If ite		1 Burial 2 Cremation 3 Removal from State	cemetery, cre	matory or other place)				
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permit. Pages 1 and Department of Health Importent: If item 27 any injury or other to once.		21. Signature of Funeral Service Licensee		2. Name and Address of F 700 Locust S				
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P.O. Box
Records,
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			For	Please 1	Type or Pring State of Ma		Depa	artment of	Health and			_	
	78p		1 - State Registrar 1. Decedent's Name	e (First, Middle, Last))		Cei	tificate of	Death	2. Date of D		<u> </u>	3. Time of Death
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	Examir		4a. Facility Name (I	f not institution, give AND HEALTI	street and number)	TEM			or Location of Dea PERRY POI		4	c. County of Dea CI	th ECIL
	Funeral Director		5. Social Security N 217 16 85	599 ¹ X	x 7. Ag JM 2□F	e (In yrs. last b 84	birthday) Yrs.	If Under 1 Year Months Days	r If Under 24 Hrs Hours Min		ay, Yea	r) Co	thplace (State or Foreign ountry) cyland
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Exartment to 1000.	by Funeral Director	Maryland 10e. Street and Nur			North	East	10f. Zip Code			10a. C	itizen of What Co	1X Yes 2 No
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98	or Ite	F.	**	ied 2☐ Married	1¥1Yes 2 ☐ 1	№ 1942 –		i Pes, specily cui I⊡Yes 2XX No		nto mican, etc.)		Black, White Specify:	te, etc.
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	To th To th comp	Ž	29b. Signature and	title of certifier	11			29c. Licen	ise number		29d. D	ate signed (Mont	h, Day, Year)
			1	h //	ny			D5273	39		FEB	RUARY 19	, 2005
i	d K		30. Name and addr	ess of person who co	ompleted cause of d	eath (Item 23a	т) (Туре,	Print)					
	0		SURESH SH	ANDELYA, I	M.D., VA	MARYLAN	ID HE	EALTHCAR	E SYSTEM,	PERRY I	POIN	T, MD 2	21902
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ě	Physici	on	1. Decedent's Name (First, Middle, Lat	st)				2. Date of De		Year 3	. Time of Death
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	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthd	ay) If Under 1 Year	MONCH If Under 24 H	rs. 8. Date of Bir			
	Director		N/A	MM 2□F	Yrs	Months Days	Hours M	rs. 8. Date of Bir in. (Month, Da Jan. 22)	2005	Maryla	e (State or Foreign and
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	r Location				10d	Inside City Limits
	Maryl f sho	to	Md. Frede	rick		derick					1 ☐ Yes 2 【XNo
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?)
	th with	aiD	7919 Runny Meade	Dr.			21702		U.	S.A	
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show cilical Examinations by notified at	by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba □ Yes 2 No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	14. Rac Blac Specify	e - American I ck, White, etc. Whit	
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. De	ecedent's Usual Occup	ation during most of w	vorkina	16b. Kind of Bu	usiness/Industr	ry
121	d within giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	lif	e. DO NOT use retired N/A	1)		N	/A	
d 2	Hyging Hyging ther		17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle			
lan	o d la	To Be	Daniel W. Court					erine A.		,0,	
Maryland	S D E E	-	19a. Informant's Name/Relationship (ailing Address (Street	and Number or	Rural Route Numb	er, City or Town,		de)
	C = N -		Daniel W. Court (Father)		9 Runny Me					
Baltimore,	0 0 = =		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify			sposition (Name of crematory or other plac urg Cremate		rch 2,	20c. Location -		
3alt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licer	see		22. Name and Addres		12	525 Bra	dbury A	Ave.
	707 e d		23a. Part I Fater the disease, or com	Davis M		J.L. Davis					
			snock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ene death. Do not 9.	enter the mode or gyin	g, such as card	ac or respiratory a	rrest,	Inte	proximate erval Between set and Death
ı	Pnysician /Medical		disease or condition resulting in death)	a. Tytre	consequence of);	Remate	wity			20	reeles
8	Examiner		Conversation to the discount of the conversation of the conversati	Chroice	Luca	Distage	_ ′			24	reeks
	od sit	Iner	Sequentially list conditions, 1 any leading to introducte cause. Enter Underlying	Dua to (or as a	continuation of):						
	be executed sician and buriat-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	consequence of);						
8760,	be es sician buria	ical E		200 10 (0) 20 2	ouriouquorius cir.						
9	ifficate t g physi as the t	70		. 0.							and the same of th
Вох	The law requires that the death certificate be executed to has been signed by the attending physician and oate 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 Ectopic pregnancy				te of delivery	
O. E	at the dea by the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 1 9□Unknown		5 Other (specify)			Mo	nth Day	Year Year
a	that the		Part II. Other significant conditions of	ontributing to death hu	t not resulting in th	e underlying cause civ	an in Part I	23a Did t	obacco use co	ribute to the co	auco of doath?
ds,	uires l signe ld be	d by	,	ormouning to abdut bu	t not rosalting in the	o underlying cause givi	on hir all i.		d		4 Unknown
S	w requir been si should	lete						24a. Was	an / 24b. V	Mara autoney f	findings available
Re	The lav	Completed			/			- autor	osy primed?	prior to comple death?	ition of cause of
of Vital Records,		Be C	25. Was case referred to medical examiner?		/		26. Place of D	1 ☐ Yes leath (Check only o		Yes 2	MO
<u>></u>	Physician: this certific al director,	To	1 Yes 20 No	Hospital: 1 Impatier			4 🗀 Nursing	Home 5□Resi	dence 6 Oth	er (Specify)	0.5.5
o uc		ion:	27. Mann of Death 1	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	y Wor		28d. Describe I	how injury occurr	ed	
Division	tend death tor: the	licat	2 Accident investigation 3 Suicide 6 Could not be		rv - At home farm	M 1 🗆	Yes 2 ☐ No	28f Location (Street and Numb	er or Pum! Po	uto Alumbor
Σ	affer affer Dire d in by	Certification:	4 Homicide determined	building, etc	(Specify)	Street, factory, office		City or Tox	vn, State)	er or Hurar Ho	ute Number,
	To the Hospital or At within 24 hours affer or To the Funeral Direc completely filled in by	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best on tiner: On the basis of and manner state	examination and/o	eath occurred at the tin	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place, a	inner as stated and due to the	i. cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed	d (Month, Day,	Year)
			many Mr.	n NIU,	MD	PES-	- 060		Februar	y 26	12005
	1		30. Name and address of person who	completed cause of de						0	
				00 North 32. Registra			Hines	re,MD	2128	7	
	Sta Registi		MAN A P	oz. negistra	. 5 Sigitature					•	
DH	MH 17 Rev 1/2	240	MAR U 7	32. Registra	w &	had .					
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Novella Dashiell 214-32-6853 Division of Vital Records, P.O. Bo

Please Type or Print in Black	Indelible Ink. E	nsure All Copies	Are Legible.
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			State of Maryland / Depar		•	_	
	1		1- State of Maryland / Department of Per Dr., 6843,05/2. Registrar Amended item# 1/1-27-05/wchd/m	3/05dhb ificate of Death	Reg.	12005	07472
	Physici	an		Dashiell	Date of Death	Day Year	3. Time of Death
	/Medic			Dashiell _	TANGARY	24 2005	2326 M
	Examir	er		4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		FCDiDSUA FEGINAL Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Willem 9. Birthr	olace (State or Foreign
	Director	4	214-32-6853 10 M XOF 70 Yrs.	Months Days Hours Min.	(Month, Day, Ye.	ar) Coui	place (State or Foreign htry)
	pus *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	stion			
	Aaryle f sho	ō	11 5 11/11				0d. Inside City Limits 1 Yes 2 No
	28a-	rect	10e. Street and Number	10f, Zip Code	10g	Citizen of What Cour	
3	illed within 72 hours after death with the Maryland Hygiene. Hydiene. Hydiene. Inter Medical Examinat must be notified at	Funeral Director	731 BUTT St	2/801	_	15.1	,
	ems ems	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. W. Armed Forces? 15. W.S. 15. W	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto		14. Race - Americ Black, White,	an Indian,
ဗ္	s affe	by Fu	1 Never Married 2 Married 1 Yes 2 No	☐ Yes 20 No Specify:		Specify:	
5-003b	stural self.	ed t		nt's Usual Occupation	16h	Kind of Business/In	1 CR
ດ :	Media	plet	(Specify only highest grade completed) (Give ki	nd of work done during most of worki NOT use retired)	าด		
7	Itled wit Hygiene other the Pent, the	Completed	11 5,	TIER		EIFEMP	Layed
⊆ .	d tal	Be	17. Father's Name (First, Middle, Last)	A .	(First, Middle, Maid	len Sumame)	
	2 ≥ 2 2	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Daisey	Marie	Elzer	1
Ma	7 te	13	11	Address (Street and Number or Rura		y or Town, State, Zfb	Code)
ē .	s 1 and if Health Item 27 other tr		20a. Method of Disposition 20b. Place of Disposit	tion (Name of		Location - City or To	own, State
e e	0 0	١.	Positional 2 Chemation 3 Hemovalitom State	conctent 1/3	21/05/4	urlock.	11
	arta orte inju		21. Signature of Funaval Service Licensee 22.1	Name and Address of Facility	00/00	# Trans	nd Home
מ	Ded Lang		Sussell fort 91			media	
			23a. Part1. Enter the disease, or complice thins that caused the death. Do not enter shock, or hear failure. List only one cause on each line.		respiratory arrest	/	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death) ASC	OV			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
-	outed od ransit	Examiner	that initiated events				
760,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
- :	cate pohysic	dlcal	d				
٥ ×	w requires that the death certains been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decaded program 23c. If yes, outcome of pregnancy	-			
X P P	death e atten	clan	in the past 12 months?	ctopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
j .	by the	hysl	1 Yes 2 No 4 Pregnant at time of death 5 C 9 Unknown				
ກໍ່ສ	requires that the een sign e d by the nould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the undi-	erlying cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
ecord	equir sen si lould I				1 ☐ Yes	2 □ No 3 □ Prob	ably 4 □Unknown
ပ္	has be	Completed			24a. Was an autopsy	24b. Were autor	osy findings available
	Dag Sag	Con			performed?	death?	·
Vital	this certificate ral director, pag	Ве	25. Was case referred to medical examinate? Hospital:	26. Place of Death		Ne.	
5	th. : After this certifical funeral director, p	To It	27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOX 4 Nuising Hon	se 5 Residence 8d. Describe how in	6 ☐Other (Specify)
	ath. r: Afte e fune	atlor	1 ⊟Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,,	
DIVISION	er der recto	Certification	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office 2	8f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
ם ב	ret DI					<u> </u>	
2	within 24 hours after death. To the Funerel Director: After it completely filled in by the funera	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of 2 Medical examiner: On the basis of examination and/or investance. and manner stated.	ccurred at the time, date and place, a stigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as stand due to	ated. the cause(s)
4	ithin (Med	29b. Signature and his of cellifier	29c. License number		ate signed (Month, L	
1	- s = 0		(Landed	450497	1	125/05	,
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	int),	,	12.10.	-
			CAMIS SNYAW 100 ECARKOI	nt) ST. SAL/	SHIM	MO	
	Sta	-	31. Date filed (Month, Day, Year) JAN 2 7 2005 32. Fistrar's Signature	.M.			
	Registr		Comment of the Party of Party				

			1 - For State of Mar Registrar	ryland / Department of Health and M Certificate of Death		ne N2005 07473
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Margaret S	DeRoche	2. Date of Death Feb 12	Day Year 7:10 P M
>	Examii Funeral Director	ner	578-42-5427 1□M 2KF 93	4b. City, Town, or Location of Death Laure1 (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Prince Georges 9. Birthplace (State or Foreign Country) South Dakota
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show any njury or other traumatic event, the Modical Examiner must be neitlined at once.	To Be Completed by Funeral Director	Md. Montgomery 10e. Street and Number 3160 Gracefield Road #1534 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 17. Father's Name (First, Middle, Last) Henrik Martinus Solem 19a. Informant's Name/Relationship (Type, Print) William H. DeRoche/Son 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) 21. Signature of Funer Service Inser	ar in U.S. 13. Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 Tyes 2 Tyes Organization (Give kind of work done during most of work life. Do NOT use retired) Librarian 18. Mother's Nam Mari Vog 19b. Mailing Address (Street and Number or Rur 9836 Belhaven Rd., Betl 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Mar. (8) 22. Name and Address of Facility DeVol. Funeral Home 2222 Wisconsin Ave.	becity Yes or No- co Rican, etc.) king Ine (First, Middle, Maid gland ral Route Number, Ci hesda, Md. Date 20c 8,05 Ar	ity or Town, State, Zip Code) 20817 Location - City or Town, State Lington, Va.
8760,	Physician /Medical Examiner the pright ransit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause). Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e death. Do not enter the mode of dying, such as cardiac Fibrillation consequence of): OPE consequence of):	or respiratory arrest,	Approximate Interval Between Onset and Death I Gear
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	al Certification; To Be Completed by Physiclan/Me	29a. Certifier 1 Certifying Physician: To the best of m	Setal déath 3 □ Ectopic pregnancy 5 □ Other (specify) 1 □ Tesulting in the underlying cause given in Part I. 26. Place of Death 26. Place of Death 27. Place of Death 28b. Time of Injury M 1 □ Yes 2 □ No 28b. Thome, farm, street, factory, office	24a. Was an autopsy performed 1 Yes 2 1 He (Check only one) one 5 Residence 28d. Describe how in 28f. Location (Street City or Town, St	1 Yes 2 No 6 Other (Specify) njury occurred and Number or Rural Route Number, ate)
	To the Ho To the Ho Bedistr To the Ful completely	Medic	29b. Signature and title of certifier LOVUM Pullman 30. Name and address of person who completed cause of death LOVEEN J. PUTHUMANA, 3	amination and/or investigation, in my opinion, death occurring the state of the sta	29d. [Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland / Dep		Mental Hygie	•
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Sterling Dorsey			2. Date of Death Month February	Day Year 3. Time of Death
	Examir		4a. Facility Name (If not institution, give Frederick Memoria	al Hospital	4b. City, Town, or Location of Dea Frederick	th	4c. County of Death Frederick
	Funeral Director		5. Social Security Number 6. Security Number 15 15 15 15 15 15 15 15 15 15 15 15 15	7. Age (In yrs. last birthday, Yrs. 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs Months Days Hours Min		(ear) 9. Birthplace (State or Foreign Country) Mo
	death with the Maryland ms 23a or 28a-f show rrust be notified at	ctor	MD. Freder	10c. City, Town or L	ocation AIRY		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ath with the Maryla s 23a or 28a-f show	Funeral Director	13832 OLL AM		10f. Zip Code 21771		Citizen of What Country?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23a may Injury or other treumatic event, the Medical Examiliation unit and Injury or other treumatic event, the Medical Examiliation unit.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
2	within 72 h ene. then "netu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) (Give	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	nking	b. Kind of Business/Industry
land 21	should be filed withir nd Mental Hygiene. marked other then matic event, Tre M.	To Be Co	17. Father's Name (First, Middle, Last) RASIL DORS			me (First, Middle, Ma	,
, Maryland	ind 2 shoul alth and M 127 Is mari	-	19a. Informant's Name/Relationship (Ty	pe Print) 19b. Maili	ing Address (Street and Number or R	ural Route Number, C	
Baltimore,	Pages 1 and 2 ment of Health ent: If item 27 I ury or other tre		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disponent commetery, cre ARRIVE	matory or other place)	Date 20	c. Location - City or fown, State FRED, 17D
Balt	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Service Libense	eens 1	2. Name and Address of Facility G	ARY L. RO.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	PHLMONARY En	BOLLS	Interval Between Onset and Death SBVFMAL HWA
3760,	te be executed ysician and se burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	APNA PHBLE PROS. CARCINOMA	iatscron g	16 DAGS
P.O. Box 68	The law requires that the death certificate be exite has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 [4 ☐ Pregnant at time of death 5 [9 ☐ Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed t should be det	by	Part II. Other significant conditions con	tributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
l Records,	'siclen: The law requ s certificate has been lirector, page 2 should	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
Vital	Physiclen: The this certificate har all director, page	Be	25. Was case referred to medical examiner?	ospital:	Other	ath (Check only one)	
of	2 2 0	7	1 Yes 2 No	1 Inpatient 2 ☐ ER/Outpatier		lome 5 Residenc	e 6 □Other (Specify)
ion	nding F th. r: After a funera	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time o Injury	28c. Injury at Work? M 1 Yes 2 No	Ess. South Do How	mary coounted
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, larm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	the Hospi vin 24 hou the Funer npletely fill	Medical	one)	ician: To the best of my knowledge, deat ler: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	irred at the time, date	and place, and due to the cause(s)
)	To To	~	29b. Signature and title of certifier	M.	. 220111	1	Date signed (Month, Day, Year)
	~		Runard to Mi	mpleted cause of death (Item 23a) (Type, IFY FRT(HY)(IK	Memorial Hos	pital, Fi	rederick, MD
	Sta	te	31. Date filed (Month Pap Year) 8 20	05 32. Angistrar's Signature	Land o		

			1 - For State Registrar	State of Ma		artment of Health a rtificate of Death		ene	
	Physic /Med Exami	cal	Decedent's Name (First, Middle, La. CAROL ANN DUTE A. Facility Name (If not institution, give	KO .		4b. City, Town, or Location of	2. Date of Death Month FEB . 1		3:15 A M
	Funeral Director	Tiei	17309 BROWN RC 5. Social Security Number 6. S	OAD 9x 7. Age	a (In yrs. last birthday)	POOLESVILI If Under 1 Year	Æ	MONTGOM	IERY place (State or Foreignuntry)
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD MONTGO		10c. City, Town or Lo		1110 20	1930 WAS	10d. Inside City Limits 1 Yes 2 No
	s 23a or 28	rai Director	10e. Street and Number 17309 BROWN RC			10f. Zip Code 20837		g. Citizen of What Cou USA	intry?
9600	d within 72 hours after death with the Maryland giene rrthen "neturel", or itams 23a or 28a-f show the Medical Examinat must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☐ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White Specify: WH	, etc.
21215-0036	s within 72 jiene. r then "nel	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5-	(Give	dent's Usual Occupation kind of work done during most DO NOT use retired) ADCASTER	of working	6b. Kind of Business/Ir	,
Maryland	should be filed and Mental Hygid markad other umatic evant,	To Be	17. Father's Name (First, Middle, Last) H. CLIFFORD AL 19a. Informant's Name/Relationship (7)			18. Mother REGI	's Name (First, Middle, Ma NA McCLOSK	aiden Sumame) EY	
	1 and 2 Health a em 27 is		SHARON REPASS 20a. Method of Disposition 1 Burial 2 Cremation 3 D	/ FRIEND	201 20b. Place of Dispo	matory or other place)	AVE., POOL	ESVILLE, Oc. Location - City or To	MD 20837
Baltimore,	parmit. Pages Department of I Important: If it eny injury or o		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service*Licen)	22	Y'S CHURCH 2 Name and Address of Facility ILTON FUNERA O. BOX 86,		ARNESVIL	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line	the death. Do not ant	er the mode of dying, such as ca	BARNESVILL ardiac or respiratory arrest	E, MD 20	Approximate Interval Between Onset and Death Smonths
8760,	cate be executed ohysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Tiscase of the first that initiated events resulting in death) Last	с	consequence of):				
.O. Box 6	The law requires that the death certificate be executed ate has been signad by the attending physician and page 2 should ba detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	! □Fetal death 3 □	Ectopic pregnancy		23d. Date of delive	ery Day Year
Vital Records, P.	ie law requires that has been signad b ge 2 should ba deta	Completed by PI	Part II. Other significant conditions co			nderlying cause given in Part I.	1 Ves	24b. Were auto	pably 4 Unknown
Vital R		Be	25. Was case referred to medical examiner?	Hospital:			autopsy performed 1 Yes 2 H	d? death? 1 □ Yes	mpletion of cause of
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Registrar

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State of Maryland / Department of Health and Mental Hygiene 005

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Physician	n	1. Decedent's Name (First, Middle, Last, HOWARD ROBERT DON	,				2. C	ate of Death	Y ^{Da} 14, 2	3. Time of De 6:33 F
/Medica Examine		ta. Facility Name (If not institution, give 1730 QCEAN GATE	street and number)			m, or Location			4c. County o	
Funeral Director		220-72-3930	x 7. Age	(In yrs. last bin		ear If Unde ays Hours	Min. (/	ate of Birth Month, Day, 1	(dai)	9. Birthplace (State or Fo Country) MD
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23a or 20 ust be no	al Dire	10e. Street and Number 5013 MATN STREET			10f. Zip Co 2163				g. Citizen of Wh USA	nat Country?
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and Mental		19a. Informant's Name/Relationship (Ty		19b.	Mailing Address (St		IS ANN (ber or Rural Rou		_	tate, Zip Code)
of Health and Ment	_	DORIS ANN DONOVAN	/MOTHER)13 MAIN S					638
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· ·	Examin		4a. Facility Name (If not institution, give street and AnniArundal Medico	d Center	Anna			4c. County of Deat	ındel
	Funeral Director		5. Social Security Number 6. Sex 120 M 2 F	7. Age (In yrs. last birthday)	Months Days	Hours Min.	Date of Birth (Month, Day, Y pril 1,		hplace (State or Foreign untry) ndia
Maryland	a-f show	ctor	Maryland 10b. County Maryland Anne Arundel	10c. City, Town or Lo	ocation Annar	, colis			10d. Inside City Limits 1 ☐ Yes 2 No
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036 ours after dec	Department of Health and Mental Hygiene. Important: or Items 23c or 28a-f show any injury or other traumatic event, If a Modical Exerthetrast be rediffed at once.	by Funeral Director	t ☐ Never Married 2∑Married 1∑Xe	s 2 □ No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2204No	ispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	iene. than "natur tre Modical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College 5+	(Give (ife.	DO NOT use retired	during most of working		b. Kind of Business/l	ng Consultir
land 2	dental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Jagat S. Dhillon			18. Mother's Name (F Rattan La	irst, Middle, Ma		-5 -00.12-02-02-02-02-02-02-02-02-02-02-02-02-02
, Mary	salth and h		19a. Informant's Name/Relationship (Type, Print) Chloe R. Dhillon / wi		ng Address (Street a	and Number or Rural A		ity or Town, State, Z S, Marylar	
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Tot	vith To 1	2	29b. Signature and title of certifier Company All M	10	Delu	75	Co	Date signed (Month)	2005
			30. Name and address of person who completed ca 1830 E. Monument 5t	use of death (Item 23a) (Type,	Print) Bultin	nore, MD	2120	5 Orik	Dinbor
-	Sta Registr		31. Date filed (Month, Day, Year) FEB 1.7 2005	gistrar's Signature	book				

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MILTON BACON STEPPEN HUSBAND 39.14 20TH ST., NE WASHINGTON, DC 20018	a)	17. Father's Name	e (First, Middle,	, Last)	<u> </u>	.0.	I FK	ESCHOOL			(First, Middle, Ma				
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27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 4 Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1. 1 Yes 2 9 Unknow	on injury its) Last ont pregnant 2 months? (2 No	ions contr	c. If yes, outo 1 □ Live bi 4 □ Pregna 9 □ Unkno	come of pregnanth 2 Peta ant at time of co	ancy al death 3(Other (specify	/)		1 Yes 24a. Was an autopsy performe	cco use co	Alonth 3 ☐ Pro D. Were autoprior to α death?	the cause of dealbably 4 Unk	th? nown
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Baitimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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ı	Physici /Medi		1. Decedent's Name (First, Middle, Las Elsie Mae Eger	t)			1,1]	2. Date of Death Month February		005	3. Time of 7: 00	Death D ^M		
	Examir	er	4a. Facility Name (If not institution, give Waldorf Healthcare)			Town, or	Location of			4c. Cour	ity of Death	7.00	_Р		
	Funeral Director		5. Social Security Number 6. Sec 220–26–4809		ge (In yrs.)6	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Feb. 5,	Year) 1909	year 2005 7:00 Inty of Death Intes 9. Birthplace (State County) Maryland 10d. Inside (1 ye) of What Country? A. Race - American Indian, Black, White, etc. scify: White If Business/Industry Store name) Son wn, State, Zip Code) 158 on - City or Town, State ton, Virgin d, Md. 2064 Approxima Interval Be Onset and Characteristic Construction of Construction of Countribute to the cause of Construction of Countribute to Completion of Countribute to Completion of Countribute (Specify) Store Country Date of delivery Month Day Date of Gelivery Maryland Date of What Country?		Foreign		
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36	d within 72 hours after death with the Maryland jiene. r than "neturet", or Itams 23a or 28a-1 show Ita Madical Examinet must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? [No	ŀ				in? (Spe Puerto F	cify Yes or No- Rican, etc.)		ace - Americ lack, White,	etc.			
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Baltimore,			20a. Method of Disposition 1 Sparial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. P	lace of Disposemetery, crem	sition (Nan natory or o	ne of ther place	March	Da 1	2005	Dc. Location	- City or To		a .		
Balti	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licens	#//	MOOS	68	. Name an Willi	d Addres	s of Facility Funer	al H	ome. P.A	١.	- 10				
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (ur as	RE s a consequ	Jence of):	er the mod	e of dying	, such as c	ardiac or	respiratory arres	AR St 180	÷	Approximate Interval Betwoonset and Di	een		
38760,	death certificate be executed ettending physician and of for use as the burial-transit	dical Examiner		c. Due to (or as	s a cons e qu	uence of):									Į.		
.O. Box 6	the y th iche	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3 [Ectopic pro								ear		
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	To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	edical	One)	sician: To the best ner: On the basis of and manner si	n examınat	wledge, death ion and/or inv	occurred a estigation,	at the tim- in my op	e, date and inion, death	place, ar occurre	nd due to the cau d at the time, dat	se(s) and n e and place	nanner as sta , and due to	ated. the cause(s)			
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(JB3		30. Name and address of person who co	1AK =	JIX	ATTIC	Print))	102 1	HIL	MECIU	Na	- WA	KP02 Drok	F02		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 2 2	005 32. Halist	rar's Signat	Jr A	porte										

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** FEBRUARY 14, 2005 3:30 P M FINKELSTEIN MILTON MORDECAI /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY 5 GREGG COURT BROOKEVILLE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1∏ M 2□ F 21, 1936 MASSACHUSETTS Director 68 DEC 152-26-0883 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1.☐Yes 2☐No Director MARYLAND MONTGOMERY BROOKEVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20833 UNITED STATES 5 GREGG COURT Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or ite any injury or other traumatic event, the Modical Examina once. 1 XYes 2 □ No If Yes, Give VIETNAM Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ NAVY CAPTAIN **MILITARY** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MORRIS FINKELSTEIN ISABEL COHEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MAXINE A. FINKELSTEIN, WIFE 5 GREGG COURT, BROOKEVILLE, MARYLAND 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2- Cremation 3 Removal from State JUDEAN MEMORIAL GDN. 2/18/2005 5 Other (Specify) OLNEY, MARYLAND 4 Donation 21. Signature of Funeral Service Licensee ZZ Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 23a. Part Finter the diseas . . . complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. 1170 ROCKVILLE PIKE, ROCKVILLE, MD Approximate Interval Between Onset and Death Immediate Cause (Final Physician MESOMELIOMA - CHRONIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yas 2 ☐ No s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has ormed? 2 🖾 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 💢 No Certification: To 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 5 | Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident s after death filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier FEBRUARY 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 MEDICAL CENTER DRIVE, #300 JOHN WALLMARK, M.D., ROCKVILLE, MD 20850 31. Date filed (Month. EB 18 ₩egistrar's Signatyre State

DHMH 17 Rev 1/2001

Registrar

2005

			1 - For State Registrar		ryland / Dep <i>Ce</i>	artment of H			iene g. No2 0 0 5	07482
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last, Carroll Mil	ler Few	٧			2. Date of Death Month February	y 17 2005	
	Examir	ner	4a. Facility Name (If not institution, give 460 Johnsville Rd	•		K	Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Security Number 219-12-1823	X 7. Age	(In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr. 28	^y ear) 9. Bir C , 1919 Ma	thplace (State or Foreign ountry) ryland
	ith the Maryland or 28a-f show	Director	10a. State 10b. County Maryland Carro		10c. City, Town or Lo	Кеута	r			10d. Inside City Limits 1 ☐ Yes 2 No
	h with t	I Dir	10e. Street and Number 460 Johnsville	Rd.		10f. Zip Code 217	57	10	g. Citizen of What Co	S.A.
900	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show that it a Madical Exerting the mailled at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑Widowed 4 □ Divorced	12. Was Decedent En Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hill If Yes, specify Cubar 1 ☐ Yes 2 🗷 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	erican Indian,
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours aft I Health and Mental Hygiene. Item 27 Is marked other then "natural", or i other traumatic event, If a Madical Exertion	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+	(Give	dent's Usual Occupa kind of work done d DO NOT use retired) farme i	luring most of work)	ing	6b. Kind of Business	
/land	2 should be filed and Mental Hyg Is marked other surmatic event,	To Be C	17. Father's Name (First, Middle, Last) James C. Few				18. Mother's Nam	e (First, Middle, M		
Man	nd 2 sho alth and I 27 Is me		19a. Informant's Name/Relationship (Ty.) Richard D. Few/ so	, , ,		ng Address <i>(Street</i> a	nd Number or Run	al Route Number,	City or Town, State, .	Zip Code)
nore,	ages 1 and 2 nt of Health t: If item 27 I r or other tra		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ R	lemoval from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	9)	Date 2	Oc. Location - City or	Town, State
Baltimore,	permit. Pages Department of I Importent: If ite eny injury or of		21. Six tur of Fyeral Service Licens	D. Xlast	22	Name and Address 104 S. Mai	s of Facility Har	tzler Fu	reagerstov neral Home o, MD 2179	2
	And icale be executed // Medical Examiner The burial-transit	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and listing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	STIVE consequence of):				st,	Approximate Interval Between Onset and Death 2 MD PTH 5
P.O. Box 68760,	requires that the death certificate be veen signed by the attending physicial hould be detached for use as the buri	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
Ś	w requires tha been signed should be det	by	Part It. Other significant conditions con		not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to : 2ДNo 3 ☐ Pr	the cause of death?
of Vital Record	The taw ate has b page 2 s	Completed						24a. Was an autopsy perform 1 Yes 2	prior to	itopsy tindings available completion of cause of 2 ☐ No
Zi.		o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	lospital: 1	2 ER/Outpatien			n <i>Check onlone</i> me 5 Residen	ce 6 Other (Spec	cify)
ion o	ding h. After fune	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time of Injury	28c. Injury Work		28d. Describe how		
Division	i Sirte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, tarm, str (Specify)	eet, tactory, office		28t. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	ne Hospitel or 24 hours afte ne Funerel Dir detely filled in I	edical	29a. Certifier (Check only one) Certifying Physical Continuous Physical Continuous Physical Continuous Physical Continuous Physical Continuous Physical Continuous Physical Continuous Physical	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	occurred at the time restigation, in my opi	e, date and place, inion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
)		Me	29b. Signature and title of certifier	inthen	m)	29c. License	number 14317		d. Date signed (Month)	* * * * * * * * * * * * * * * * * * * *
	WSL-		30. Name and address of person who come with the R. L. I.				11 (11)			
	Sta Registr	te	31. Date filed (Month, Day, Year) FEB 1 8	32. Registrar	s Signature	1				

			1 - For State Registrar	State of Maryl		artment of H			giene Reg. No.2 0 0 5	07483
	Physici	an	1. Decedent's Name (First, Middle, Last)	D 1				2. Date of Dea		3. Time of Death 2:45 P. M
)	/Medic	al	William E. 4a. Facility Name (If not institution, give si	treet and number)	·		Location of Deat		4c. County of Deat	h
			Southern Maryland Hosp 5. Social Security Number 6. Sex		vrs. last birthday)	If Under 1 Year	Clinton If Under 24 Hrs	8 Date of Birth	Prince Ge	Olige'S hplace (State or Foreign
	uneral irector		219-12-3204	M 2□F	97 Yrs.	Months Days	Hours Min.		r 14, 1907 M	aryland
land	MO MI		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ocation	*			10d. Inside City Limits
е Магу	de-f-eh	ctor	Maryland Prince Geo	rge's	L	anham				1XXXYes 2 ☐ No
with th	e or 28	Director	10e. Street and Number			10f. Zip Code	0706		10g. Citizen of What Co U.S.A.	untry?
death	ms 23	nerai	9700 Linwood Avenue	2. Was Decedent Ever i	n U.S. 13.	Was Decedent of H		Specify Yes or No-		
d 21215-0036 filed within 72 hours after death with the Maryland	to whenlar rygetter than "neturel", or flems 23e or 28e-f show marked other than "neturel", or flems 23e or 28e-f show matic event. Its Medical Exempler must be notified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? t ☐ Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 X No	Specify:	to Hican, etc.)	Black, White	
15-0	netur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo	rking	16b. Kind of Business/	ndustry
ZTZ withir	riygiene. ther then ent. the Me	dwo	Elementary/Secondary (0-12) 8th grade	College (1-4or 5+)		∞ k	"		D.C. Governme	nt (Retired)
	d other	Be	17. Father's Name (First, Middle, Last)	T 1			18. Mother's Na		Maiden Surname)	
arylan should be	and Meris is marke	မှ	Robert Lee		19b. Mailii	ng Address (Street	and Number or R	Elizabet	n Ford or, City or Town, State, 2	(ip Code)
, Ma and 2 s	27 is		Mr. Andrew L. Chase (So	n-In-Law)	9700	Linwood Ave		n, Maryland	1 20706	
Pages	Department of rest Importent: If Item eny injury or other once.		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State H	b. Place of Dispo cemetery cre- ermony Men	osition (Name of matory er other plac Orial Fark	Febru	pary 24, 20	20c. Location - City or 105 Landover,	
Balt permit.	Importent: eny injury c		21. Signature of Funeral Service License	Steam	1	2. Name and Address 39 H.nt Pla			neral Home, In	rc.
	ysician ledical		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	him Pres					Approximate Interval Between Onset and Death
8760, sate be executed	physician and strength to burial-transit	dical Examiner	Sequentially list conditions, if any, leading to limited late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
O. Box 6	ittending or use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	dc. If yes, outcome of pre 1 Live birth 2 f 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
ds, P.	signed by the a Id be detached f	þ	Part II. Other significant conditions cont Congretative Heavit	tributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
	cate has been si , page 2 should l	Completed	Acute fund Fail	inc					an 24b. Were au prior to death?	topsy findings available ompletion of cause of
	r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 CEP/Outpatier	nt 3 DOA Oth	0.0	ath (Check only or	ne) dence 6 □Other (Spec	
of Phy	n. After this funeral d	n: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea				7	now injury occurred	my)
	lor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - /	At home, farm, str	M 1 🗆	Yes 2 □ No		Street and Number or Ru	ral Route Number,
- ò	rs arrer ral Dire led in b		4 Homicide	building, etc. (Sp				City or Tow		
Hospital	within 24 hours after o To the Funeral Direc completely filled in by	edicai	29a. Certifier 1 ☐ Certifying Phys (Check only one)	ician: To the best of my er: On the basis of exan and manner stated.	knowledge, deat nination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the durred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the	within 24 To the Fi	Me	29b. Signature and title of certifier			29c. Licenso	e number	- 2	29d. Date signed (Month	, Day, Year)
. (10)		3.71	5120		February 18 2	200
2-1	1)		30. Name and address of person who cor Richard Falmer mi)	BZB Junther		Print) SE Surte 31	2 Wah	nghin DC	20032	
	Sta Registi		31. Date filed (Month, Day, Year) FEB 2 2 2005	82. Registrar's S		K)		J		

			1 - For State Registrer	State of M		d / Depa		f Health	and M	lental Hy		2005	07484
	Physic	ian	1. Decedent's Name (First, Mid-	dle, Last)						2. Date of De	aath Da	y Yeer	3. Time of Death
	/Medi		KATHALEEN McC	ABE FRANKLIN						tebru			
	Exami	ner	4a. Facility Name (If not instituti	, /			4b. City, Tow					3. Time of y Year 2007 3. Time of y Year 2007 3. Time of y Year 2007 3. Time of y Year 2007 3. Time of y Year 2007 3. Time of y Year 2007 3. Time of y Year 2007 3. Time of y DELAWARE 10d. Inside Cit 1 Yes 14. Race - American Indian, Black, White, etc. Specify: WHITE ind of Business/Industry TILLARY Sumame Or Town, State, Zip Code 39 ocation - City or Town, State MAR, DE O, DE Approximate Interval Belw Onset and D 2	
			5. Social Security Number	Healthcar		last birthday	If Under 1 Ye		ler 24 Hrs.	B Data of Bir			
	Funeral Director	_	222-05-5355 Usual Residence of Decedent	1 1 M 2 K E	38	last birthday) Yrs.	Months Da			8. Date of Bir (Month, Da 1/27/1	917		
	within 72 hours after death with the Maryland sine. than "natural", or Items 23s or 28s-f show is Madical Examinst must be notified at	tor	10a. State 10b. Coun DELAWARE SUS			y, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 No
	ith the or 28%	Funerai Director	10e. Street and Number				10f. Zip Cod	le			10g. Cit	izen of What C	Country?
	238 or	aiD	RT. 3 BOX 158A				199	66			USA		
	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	.S. 13.	Was Decedent If Yes, specify C	of Hispanic Suban, Mexi	Origin? (Specan, Puerto	ecify Yes or No Rican, etc.)	D-		
9	or It	y Fu	1 Never Married 2 Ma	arried 1 ☐ Yes 2 X If Yes, Give	No	1	1 □ Yes 2 X □			,			
Š	72 hours "natural", dical Ex	d by	3 Widowed 4 □ Divorce							<u> </u>	101.15		
r.	nat	Completed	(Specify only high	ent's Education nest grade completed)		(Give	dent's Usual Oc kind of work do DO NOT use re	cupation one during n tired)	ost of work	in <i>g</i>	160. K	ind of Busines:	s/industry
Ç	within than	mc	Elementary/Secondary (0-12)) College (1-4or	5+)		EMBLY W				DIS	TILLARY	7
7	be filed within tal Hygiene. I do other than event, the Me	ပိ	17. Father's Name (First, Middle	e, Last)		2100	DIDDI W		ther's Name	First, Middle			
מ	should be not Mental marked o	- m	JOHN F. McCABE	SR.				EL	LA BUI	NTING			
Maryland 21215-0036	permit. Pages 1 and 2 should be permit. Pages 1 and 2 should be Department of Health and Menta important: If Item 27 Is marked any hijury or other traumatic e pnes.	-	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailir	ng Address (Str	eet and Nur	nber or Rura	al Route Numb	er, City o	or Town, State,	Zip Code)
Σ	alth a		FRANK G. MURR	AY / SON		RR 3	BOX 73	-C, D	AGSBOI	RO, DE	199	39	
97	of He		20a. Method of Disposition	n 3 Removal from State		Place of Dispo cemetery, crei	sition (Name of natory or other	place)		Date	20c. Lo	ocation - City o	r Town, State
Ĕ	Page nent ant: It		'4 □ Donation 5 □ Other			EMATOR	Y OF DE	LMARV	2/20	0/05	DELI	MAR, DE	
Reltimore	permit, Departr Imports any Inji		21. Signature of Funeral Service	e Licensee			. Name and Ad		-		anan	0 00	
	1 205 2		Nichord 1	· Watson	7	W	ATSON F	UNEKA	L HOME	s, Mill	SBOK	O, DE	
	Pnysician		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition	st only one cause on each li	ine.								Approximate Interval Between Onset and Death
09280	Medical cate be executed behavioran and bhysician and sthe burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or as b Due to (or as d Due to (or as d Due to (or as d Due to (or as d Due to (or as d Due to (or as d Due to (or as d Due to (or as d Due to (or as d Due to (or as d Due to (or as d Due to (or as d Due to (or as d Due to (or as d Due to (or as d	a conseq	uunce or):	cers	-UCF	se-le	- D.	rec./	' E	10 year
leen O Box 6	din din	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 sonths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	ldeath 3□	Ectopic pregna Other (specify						- ,
9 0	- 5 5 6	ed by Pł	Part II. Other significant condi	_	out not res	ulting in the u	nderlying cause	given in Pa	rt I.				
Records	(0	Completed								24a. Was auto perfo 1 Yes	psy ormed2	prior to death?	completion of cause of
(N)	Physicien: this certific ral director,	Be (25. Was case referred to medic examiner?	11						(Check only			
7		P	1 ☐ Yes 2 ☐ No			ER/Outpatier							ecity)
		ion:	27. Manner of Death		iry iy Year)	28b. Time of Injury		njury at Work?		28d. Describe	how injur	y occurred	
C :	r Attending er death. rector: Afte by the fune	cat	2 Accident invest	stigation	iuma At ha	omo form etc		1 □ Yes 2	-	29f Location (Ctroot on	d Alumbos os C	Purel Paule Alumbar
Cank	in the second	ertification:		mined 28e. Place of In	tc. (Specif	y)	eet, factory, on	ce		City or To			ruras moute inumber,
1	To the Hospital within 24 hours a To the Funeral C completely filled	edical C	29a. Certifier 1 certify (Check only one) 2 Medical	ying Physician: To the best at Examiner: On the basis of and manner st	of examina	wledge, death	n occurred at th vestigation, in n	e time, date ny opinion, d	and place, leath occurr	and due to the red at the time,	cause(s) date and	and manner a I place, and du	s stated. e to the cause(s)
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1	12)	D Q	140			36	564	36003	Č	250	way 19	7, Zong-
	109		30 Name and address of person	wild mid	death (Item	п 23a) (Туре, Сент-	Print)	LA?	3.11	hori	o . te	15 21	7, 2005- 229
	St Regist	ate trar	31. Date filed (Month, Day, Yea	3 2005 32. egisti	rar's Signa	ture	mules						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1²⁵, Feb. **Physician** John J. Gilroy 3:45 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Western Maryland Hospital Center Hagerstown Washington 5. Social Security Number 212-24-6716 8. Date of Birth

Dec • 12, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 1927 MD **Funeral** Months 77 1**X** M 2 □ F Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow event, the Medical Examiner must be notified at MD Middletown Frederick 1 Yes 2 No Director 10e. Street and Number 8132A Bolivar Rd. 10f. Zip Code 10g. Citizen of What Country? ö 21769 USA Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Deportment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any njury or other traumatic event, the Medical Examinations. Yes 2 NoW . W . 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 assembly line mack truck 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James M. Gilroy Frances Shank ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Gilroy (Sister) 8132A Bolivar Rd., Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ R

1 ★ Donation 5 □ Other (Specify) 3 Removal from State Lutheran Cemetery 2/18/05 Middletown, MD 21. Signature of Funer particle Liber Bonard dd B: of Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause) on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia 7-10 DAY) disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed udden that initiated events resulting in death) Last and Due to (or as a consequence of): عارب عالم على المراكب كالم كالم Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? certificate 1 ☐ Yes 2 ☑ No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other:XX Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)4656 2.1505 1500 Pennsylvania Avenue who completed cause of death (Item 23a) (Type, Print) Hagerstown, Md 21742 500 PENS46 31. Date filed (Month Day Pres) 2 2005 State Registrar

lton A. (Gar	ay Please Type or Print in Black Ind				•	•	0 71 0 0
5		1- State Registrar Amend Items State of Maryland Apends Certification Control of Certification Control of Certification Certific	ificate of	no Death	ר	Reg.	ZUU5	0/486
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/Media	cal	MILTON A. GARAY	th City Town o	or Logation		bruary	15, 200 4c. County of De	
Examir	ner	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital 3151 University Blvd	4b. City, Town, o Silve Wheaton	r Spr	ring			mery Co
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under	r 24 Hrs. 8. Da	ate of Birth fonth, Day, Ye	9. E	Birthplace (State or Foreign
Director		223-91-5886		1	AP	RIL 11	,1969 E	L SALVADOR
yland		10a. State 10b. County 10c. City, Town or Local						10d. Inside City Limits
ith the Marylan or 28a-f show	ecto	MD PRINCE GEORGE BELTSVILL				1.0	C':: (14f) .	1 AYes 2 No
ified within 72 hours after death with the Maryland Hygiene. Other then "natural, or Itema 23e or 28e-f show only, it is Macified Expointer meat be notified at	Funeral Director	10e. Street and Number 4707 CARDINAL AVE.	10f. Zip Code 20705			1 -	Citizen of What EL SALVA	
death	nera		as Decedent of H	dispanic Or	rigin? (Specify Y			merican Indian,
s after	by Fu	1X Never Married 2 Married 1 Yes 2X No If Yes, Give		SALVA		. 5(0.)	Specific	ISPANIC
2 hour	ed b					166	b. Kind of Busines	
6. "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LABO	nt's Usual Occup nd of work done O NOT use retired R	during mo. d)	st of working		ROOFING	
iled wi dygien ther th		N/A 17. Father's Name (First, Middle, Last)		18 Moth	ner's Name (Firs	t Middle Mai		
yicality Z I A	To Be	JOSE MANUEL ADONIAS GARAY	:		·		JS LOVOS	
S P E E							ty or Town, State	
C, IV		- Action of the second of the			Date	-	SE, VA 22	
Pages nent of land: If Its		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	ory or other place		2/25/05	1		, SALVADOR
Dealthillore, Win		21. Signature of Funeral Service Licensee 22. N		ss of Facil	ity ARLING		NERAL HO	
0 88E58		There Therewas					ON, VA 22	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart killure. List only one cause on each line. Immediate Cause (Final	the mode of dyin	ng, such as	s cardiac or resp	iratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):						
Examiner		Sequentially list conditions b.						
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Une are or in by that initiated events.						
6 be executed sician and e burial-transit	Exan	that initiated events c						
ate be ex nysician he buria	cal	d						
siclan: The law requires that the death certificate certificate been signed by the attending phys rector, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23c, If yes, outcome of pregnancy					Dad Date of	(ali-sa)
d for u	cian	in the past 12 months? 1 Ver 2 No. 1 Ver 2 No.	ctopic pregnancy Other (specify)	/			23d. Date of d Month	Day Year
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The la te has	отр					autopsy performed Yes 2□	? death'	
stan: entifica ctor, p	BeC	25. Was case referred to medical examiner?		26. Plac	e of Death (Che			
Physic this ce	မ	1 X Yes 2 No Hospital: 1 □ Inpatient 2 Y ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		4 🗆 N			6 □Other (Sp	pecify)
ding I	tion	1 Natural 5 Pending (Month, Day Year) Injury	28c. Injur Wor M 1	yat k? Yes 2.∐	6/		trouts	/
Attener dear dear dector.	Certification;	Sucide Homicide Homicide Sucide Sucide Gudinot be determined Sudding etc. (Specify)	C		28f. Lo	ocation (Street itv or Town, Si	and Number or	Rural Route Number,
raf Dir		ledd	lye		NA	roles, 1	empland	
To the Hospital or Attending Physician: The within 24 hours after dauth. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investance and manner stated.						
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Me	29b. Signature and title of certifier	29c. Licens	e number		29d.	Date signed (Mo	nth, Day, Year)
5		Theoder Me Tight	OCM	Œ		Fe	bruary 1	16, 2005
		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri		nn St.	root D	.1+4	n M	land 01001
Sta	ite	31. Date filed (Month, Day, Year) 32 Registrar's Signature	111 Per	וו טנו	reer Ba	ıı linor	e, Mary	land 21201
Registr		31. Date filed (Month, Day, Year) FEB 1 8 2005	A. J					

		State Registrar			Certifica	e of Dea	th	F	leg. No.	2005	07107
Physicia	an	1. Decedent's Name (First, Middle, Last,)					2. Date of Dea Month	Day	Year	3. Time of Death /
/Medic		ZACHARY	GREEN	BAUM				FEBRUAR		, 2005	10:10 P ^M
Examin	er	4a. Facility Name (If not institution, give	street and number)			Town, or Location	on of Death			County of Death NTGOMER	
F		SUBURBAN HOSPITAL 5. Social Security Number 6. Sec	x 7. Age	(In yrs. last birt	BETH	1 Year If Un	der 24 Hrs.	8. Date of Birtl	1	9. Birthi	place (State or Foreign
Funeral Director		579-38-9418 Usual Residence of Decedent	M 2 🗆 F	87	rs. Months	Days Hou	rs Min.	MAY 10,	191	7 Polai	
anyland show	or	10a. State 10b. County		10c. City, Town		-		-			10d. Inside City Limits 1 Yes 2 □ No
28a-f	Director	MARYLAND MONTGOME I	ΧY	SILVER		Code			10g. Citiz	en of What Cou	ntry?
a or	<u>-</u>	3210 N LEISURE WO	RID BLVD	ΔРТ. 9	04 209				U.S		
death	Funerai		12. Was Decedent E		13. Was Dece	dent of Hispanic	Origin? (Sp	ecify Yes or No-		4. Race - Ameri	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If term 27 is marked other than "patural", or items 23a or 28a-f show any Injury or other traumatic event, It a Modical Examinar must be notified at once.	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	0	1 ☐ Yes	cify Cuban, Mex		Hidan, etc.)		Black, White, Specify: WH]	
in 72 hou n *natura	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		Decedent's Usu (Give kind of w life. DO NOT t	al Occupation ork done during rise retired)	nost of work	ing	16b. Kin	d of Business/In	ndustry
y with jene. r thar	mo	Elementary/Secondary (0-12)	College (1-4or 5-		INESS E	XECUTIV	E	İ	DRY	CLEANI	NG
d be filed antal Hyg ad othe c event,	Be	17. Father's Name (First, Middle, Last)	GREENBAUM			18. M		e (First, Middle,		Sumame) UBENSTE	TN
should nd Me mark mati	은	NACHUM 19a, Informant's Name/Relationship (7)		19b.	Mailing Addres			al Route Numbe			^{Code)} 20906
nd 2 ilth ar 27 is r trau		ROSE N. GREENBAUM	/WIFE								PRING, MD
of Hear		20a. Method of Disposition		20b. Place of	Disposition (Na	me of		Date		ation - City or T	
Page nent c		1 🖾 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)			N MEM. (02/17	7/2005	OLNE	Y, MARY	LAND
permit. Departn Imports any Inju		21. Signature of Funeral Service Licens			22. Name a	nd Address of Fa	FUNERA	J. DTREC	TTON	. INC.	
825 2	114	Donald . X			• 1091 F	OCKVILL	E PIKE	, ROCKV	ILLE	, MD 20	852
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line	e <i>U</i>			as cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. METASTAT Due to (or as a	CIC ADEN		OMA					9 MONTHS
Examiner		Sequentially list conditions,	b. GASTRIC	ADENOCA							9 MONTHS
ed sit	Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury	Due to (or as a	t correspondentes t	л f.						
be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):						
e be e	<u>m</u>	l	d								
tificat ng phy as the	ledi										
The law requires that the death certificate Lite has been signed by the attending physic rage 2 should be detached for use as the b	sician/Medic	in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐Ectopic p 5 ☐ Other (s				2	3d. Date of deliv Month	ery Day Year
res that the de signed by the a be detached t	Physi	9 ☐ Unknown Part II. Other significant conditions co	ntribution to death bu	t ant resulting in	the underlying	rause given in P	art I	23e Did to	bacco us	se contribute to t	the cause of death?
uires ti n signe	b	SYNDROME OF INAPP	_			accoo givan iii v					bably 4 Unknown
law require as been si 2 should b	Completed	DIABETES MELLITUS						24a. Was autop	sv	prior to co	opsy findings available ompletion of cause of
	Con	ATRIAL FIBRILLATI	ON					perfor		death?	2 No
clan: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Othor		h (Check only o			
Physician: rthis certific ral director,	2	1 ☐ Yes 2X No 27. Manner of Death	1 A Inpatier	nt 2 ER/Ou	tpatient 3 D	OA Other: 4 = 28c. Injury at		me 5 Resid		Other (Special	fy)
De la	atlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) li	njury M	Work?		200. 20001120 11	ovi injury	00001100	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ertification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	rm, street, facto	y, office		28f. Location (S City or Tow		Number or Run	al Route Number,
ospita hours uneral ly filled	edical C	(Check only 2 Medical Exam	rsician: To the best of iner; On the basis of and manner sta	examination an							
24 24 F	D	one)	and mainler sta	lou.							

State Registrar

DHMH 17 Rev 1/2001

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

WILLIAM F. SIMONDS, 31. Date filed (Month, Day, Year) FEB 1 8 2005

D36520

1.D., 3100 OLD GEORGETOWN ROAD, BETHESDA, MD 20814

(MD)

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F		d Mental Hy	rgiene	05	07489
			Decedent's Name (First, Middle, La	st)				2. Date of De	aath		3. Time of Death
	Physici /Medio		PHYLLIS	D. G	OLDBERG			FEBRUA	RY 15,	2005	2:25A M
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of D	leath	4c. Count	y of Death	
			HOLY CROSS HOSP	ITAL			R SPRIN	iG	MON	TGOME	RY
	Funeral Director		577-42-3295	ex 7. Age	71 Yrs.	Months Days	Hours N	Min. 8. Date of Bi	1, 1933	9. Birthp Cour MAR	place (State or Foreign ntry) XY LAND
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			·		10d. Inside City Limits
	Many f sh	ğ	MARYLAND MONTGO	MEDV	Ç T	LVER SPR	INC				1 ☐ Yes 2 ☐ No
	r 28e	rec	10e. Street and Number	PIEKI		10f. Zip Code	LNG		10g. Citizen of	What Cou	
	h with	E D	805 LOMBARDY C	OURT		209	901	Ų	NITED S	TATES	OF AMERICA
	deat	ner	11. Marital Status	12. Was Decedent 8 Armed Forces?		Was Decedent of H	ispanic Origin	? (Specify Yes or No			can Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itams 23e or 28e-f show many highty grother treumatic event, the Madical Examinar must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2XN If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 🗓 No	Specify:	deno Alcan, etc.)	Specia	rck, White, fy: W	etc. VHITE
5-0	72 ho	etec	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occup	ation during most of	workina	16b. Kind of B	usiness/In	dustry
21	vithin ne. han	ğ.	Elementary/Secondary (0-12)	College (1-4or 5	+)	kind of work done of DO NOT use retired	1)			ED ST	
	filed with Hygiene. other thau	ပိ	12 17. Father's Name (First, Middle, Last)	1	CL	ERICAL	10 Mathoda	Name (First, Middle		ERNME	NT
Maryland	ould be f Mental P wrked of	Be	WILLIAM BLUMBER					YE ROSENB		пө)	
2	should nd Men marke umatic	ဥ	19a. Informant's Name/Relationship (19h Maili	no Address (Street		r Rural Route Numb		State 7ir	Code
≥	od 2 sho lith and 27 Is mu		BERNARD GOLDBERG					, SILVER			
ē,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any Injury or other tre-		20a. Method of Disposition		20b. Place of Dispo	osition (Name of		Date	20c. Location	- City or To	own, State
Baltimore,	Page ento nt: #		1 \$\overline{\mathbb{R}}\text{Burial} 2 \$\overline{\mathbb{C}}\text{Cremation} 3 \$\overline{\mathbb{X}}\text{Cremation} \text{3 \$\overline{\mathbb{C}}\text{Donation} 5 \$\overline{\mathbb{C}}\text{Other} \$(Specification of the context of the cont		KING DAVI	matory or other place		02/17/05	FALLS	CHUR	CH, VA
ij	mit. f porter inju		21. Signature of Funeral Service Licer		the second second second second			ERAL DIRE			.011, 111
m	permi Depar Impo any ir	1	Donald (.	Statelle				EKAL DIKE			1952
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the eath. Do not en	ter the mode of dyin	g, such as car	diac or respiratory a	rrest,	.HD 20	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ASCUD							Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):						
	Examiner		Sequentially list conditions,	b. ATRIAL							
	p ii	Iner	cause. Enter Underlying Cause (Disease or injury	,	nonsequence of):						
	ecute and -trans	cam	that initiated events resulting in death) Last	c. COPD						_	
60,	cate be executed physicien and s the burial-transit	dical Examiner		HYPERTE	NSTON					1	
68760,				d	1101011						
_	death certifi e ettending ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy				23d Da	ite of delive	20/
Вох	death e etter	ciar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at 1		Ectopic pregnancy Other (specify)				onth	Day Year
P.O.	that the de ted by the e detached f	hysi	9 Unknown	9□ Unknown							
	The law requires that the ste has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use con	inbute to th	ne cause of death?
rd	w require been sig should b							_ 1 🗆	Yes 2□No	3 ☐ Prob	ably 4 X Unknown
Records,	e law requ has been je 2 shoul	Completed						24a. Was	an 24b.	Were auto	psy findings available
Ä	The I	Eo						— autoj perfo 1 Yes	rmed?	death? 1 ☐ Yes	mpletion of cause of
Vital	ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of	Death (Check only o	A		
of V	s s	To	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatier	nt 2 ER/Outpatier	nt 3□ DOA Othe	er: 4 ☐ Nursin	ig Home 5 ☐ Resi	dence 6 □Oth	er (Specif	γ)
_	Th (0 0		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work	c?	28d. Describe	how injury occur	red	
Sio	tendi leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	a			Yes 2 □ No				
Division	or At	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, str . <i>(Specify)</i>	eet, factory, office		28t. Location (. City or To	Street and Numb wn, State)	er or Rura	I Route Number,
	pitel		29a. Certifying Ph	veicien: To the best o	f my knowledge, deat	h ongurred at the time	o data and al	non and due to the			
	the Hospitel or Attending hin 24 hours after death. the Funerel Director: After Inpletely filled in by the fune	Medical	(Check only 2 Medical Exam	ysician: To the best on niner: On the basis of and manner stat	examination and/or in ed.	vestigation, in my or	oinion, death o	ace, and due to the courred at the time,	date and place,	and due to	ated. the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Aft completely filled in by the fun	Me	29b. Signature and title of certifier		, 5	29c. License	number		29d. Date signe	d (Month,	Day, Year)
	-		1 AM	Als VI	enM	D)	18813		FEBRUA:	RY 15	, 2005
•	(D		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type:	Print)					
			IRA TAUBER, MD		EORGIA AVE		SILVER	SPRING. M	D 20902		
	Sta		31. Date filed (Month, Day, Year)	32 Registra	r's Signature						
	Registr	ar	FEB 1 8 20	105 Keneua	st for	uli					

DHMH 17 Rev 1/2001

		1. Decedent's Name (First, Middle, La	st)		rtificate			2	Date of Deat	h _		3. Time of Death
sicia		Virginia	Lawson Givhan						Month Februa	ry 11,	2005	6:25 P.M
edica mine		4a. Fecility Name (If not institution, give	re street and number)		4b. City,	Town, or	Location of [Death		4c. Count	y of Deeth	
		Southern Maryland Ho	spital			C1	Linton			Prino	e Geor	ge's
1		5. Social Security Number 6. S 577–30–7552	Sex 7. Age (In yrs. la 1□ M 2√√F 82		If Under Months		If Under 24 Hours	Hrs. 8	Date of Birth (Month, Day (Anuary	Year) 1923	9. Birthy Coul Vir	place (State or Foreign ntry) ginia
		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or L	ocation							10d. Inside City Limits
	ctor		George's		_	Sitl	and					1 X Yes 2 ☐ No
	I Dire	10e. Street and Number 2302 Brooks Drive	# 3 (V)		10f. Zip	Code 207	746		1	0g. Citizen of U.S	What Cou	ntry?
	nera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Deced	lent of His	spanic Origin	? (Speci	fy Yes or No- can, etc.)	14. Ra		can Indian,
Part Erry	מא בת	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 Yes 2		Specify:	491071	oarr, etc.)	1	y: Blac	
	Completed by Funeral Director	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	rk doné di	uring most o	f working		16b. Kind of B	lusiness/In	dustry
	COT.	12th grade		C.	lerk					Banking		stry
l,	Be	17. Father's Name (First, Middle, Last Ernest W. I	areco				18. Mother's	Name (First, Middle, I		ne)	
	2					-			Eva S.			
ı		Rose M. Blassingare (-				Route Number			Code)
		20a. Method of Disposition		ace of Dispo	cition (Name matory or ot	S DIT	ve #304	Dat	lard, Ma	20c. Location	- City or To	own, State
		1 ☐ Burial 2XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State che	metery, cre sapeake	matory or ot e Cremet	tory.	"Inc. Fe	ebna	ry 19, 2	005 Be	ltsvil	le, Maryland
		21. Signature of Funeral Service Lice			2. Name and			Ro	lirs FU	neral Ho	me, Ir	c.
		Junet C.	Indorsan	11	1339 Ha	nt PI:	ace N.I	F Who	shinotan	DC	20019	
ı		23a. Part? Enter the disease, or com- shock, or heart failure. List only	op leations that caused the death.	. Do not en	ter the mode	e of dying	, such as ca	rdiac or r	espiratory arre	est,	O X ILY	Approximate Interval Between
ı		Immediate Cause (Final disease or condition	SEPS	S							- 4	Onset and Death
		resulting in death)	Due to (or as a consequ		0	A	War (SA)				-	
		Sequentially list conditions.	. CARDI		00 Kt	4/1	14					
Examiner		Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence or):	_							
YAIT.	5	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):								
•	cal		d ABDOM	INAI	- m	145	2.2					
	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	⊒Ectopic pre ⊒ Other (spe						te of deliver	ery Day Year
by P		Part II. Other significant conditions	contributing to death but not resu	Iting in the u	inderlying ca	ause give	n in Part I.					he cause of death?
Post.	E C								1 🗌 Ye	s 2 No	3 Prot	pably 4 Unknown
	Completed							-	24a. Was a autops perform	y ned/2	Were auto prior to co death? 1 Yes	ppsy findings available mpletion of cause of 2 No.
	D E	25. Was case referred to medical examiner?		-			26. Place of	Death (Check only on			
	2	1 ☐ Yes 2 No		R/Outpatie		A Othe	4 🗆 Nursi	ng Home	5 🗆 Reside	nce 6 🗆 Oth	ner (Specif	(y)
	ou:	27, Manner of Death 1 Natural 5 ☐ Pending	(Month, Day Year)	28b. Time o Injury		8c. Injury Work	?		d. Describe ho	w injury occur	red	
	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	00 Blace of leium. At her	ne, farm, st	M reet, factory	_	′es 2∐No		Location (St City or Town		er or Rura	al Route Number,
		29a. Certifier 1 Certifying Pl	hysician: To the best of my know	vledge, deat	h occurred a	at the time	e, date and p	place, and	d due to the ca	luse(s) and m	anner as s	tated.
	Medicai	one)	miner: On the basis of examinati and manner stated.	On and/or in								
ľ	g	29b. Signature and title of certifier				License				9d. Date signe		
		Monnes	completed cause of death (Item 92 OXW HILL Registrar's Signature		\overline{D}	148	129		+	C1213	120	0.5
1	1	30. Name and address of person who										

Lidia garcia Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	~	For State Registrar	State of Ma	aryland / L	Department of H Certificate of L			eg. No.	05	07491
iciar	n	Decedent's Name (First, Middle, La.	Lidia	Mar	Garcia		2. Date of Dea Month	th Day	Year	3. Time of Death
dica nine		4a. Facility Name (If not institution, giv	i		4b. City, Town, or	Location of Death			unty of Death	1
al or		5. Social Security Number 6. S		e (In yrs. last bir	thday) If Under 1 Year Months Days 8 5	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) June 22	Year)	9. Birth Cou	place (State or Foreig intry) vland
,		Usual Residence of Decedent 10a. State 10b. County Maryland Carroll	County	10c. City, Tow	n or Location aneytown					10d. Inside City Limit
Totografia iona	Direct	10e. Street and Number 114 Divern Street	-		10f. Zip Code 21787	7		-	of What Cou	-
Do Completed by European Director	runera	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent I Amed Forces? 1 ☐ Yes 2 🕅		13. Was Decedent of Hi If Yes, specify Cuba			E	Race - Amer Black, White	
	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			Spa	nish			ite
ploto	Сощріете	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		i+)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	furing most of work	ing	16b. Kind o	of Business/Ir	ndustry
000	o ge	17. Father's Name (First, Middle, Last, Jose A. Garcia)			18. Mother's Name Mercedes			name)	
		19a. Informant's Name/Relationship (Mercedes Boleira—(Mailing Address (Street a		al Route Number neytown			p Code) 21787
		20a. Method of Disposition 1 □ Burial 2 【XCremation 3 □ 4 □ Donation 5 □ Other (Specif		cemeter	Disposition (Name of ry, crematory or other place	-1	. 2		on - City or T	
			v)	SILLUIS	sburg Cremato			Smiths	sburg,	Maryland
- BOUCE	ľ	21. Signature of Funeral Service Licer		Silituris	22. Name and Addres 136 East Ba	orium 2 es of Facility Sk	:005 :iles Fur	neral	Home	Maryland , MD 21787
To D		21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	Jum .		22. Name and Addres	orium ₂ s of Facility Sk altimore	iles Fur Street	neral Tane	Home	
al er		21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each lin a. Due to (or as:	the death. Do ne. Show a consequence	22. Name and Address 136 East Band enter the mode of dying of):	orium ₂ s of Facility Sk altimore	iles Fur Street	neral Tane	Home	, MD 21787 Approximate Interval Between Onset and Death
al er	ammer	21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each line. Due to (or as: Due to (or as: C. Premo	the death. Do ne.	22. Name and Address 136 East Banot enter the mode of dying of):	orium ₂ s of Facility Sk altimore	iles Fur Street	neral Tane	Home	, MD 21787 Approximate Interval Between Onset and Death
al er	Examiner	21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events	plications that caused one cause on each line. Due to (or as: Due to (or as: C. Premo	the death. Do ne. Shoot a consequence a consequence with the consequence and	22. Name and Address 136 East Banot enter the mode of dying of):	orium ₂ s of Facility Sk altimore	iles Fur Street	neral Tane	Home	, MD 21787 Approximate Interval Between Onset and Death
	edical Examiner	21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events	plications that caused one cause on each line. Due to (or as: Due to (or as: C. Premo	the death. Do ne. a consequence a consequence a consequence of pregnancy 2 Fetal death	22. Name and Address 136 East Banot enter the mode of dying of):	orium ₂ s of Facility Sk altimore	iles Fur Street	neral Tane	Home	Approximate Interval Between Onset and Death Cours 8 months 6 months
a de la company	by Physiciatumedical Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 17 No	plications that caused one cause on each lir a. Due to (or as: b. Due to (or as: c. Due to (or as: d. Due to (or as: under the companies of the companies	the death. Do ne.	22. Name and Address 136 East Ba not enter the mode of dying of): 3 Ectopic pregnancy 5 Other (specify)	orium 2 ss of Facility Sk altimore g, such as cardiac	iles Fur Street	Deral Tane Past, 23d.	Home ey town Date of delive Month to the contribute to the contri	Approximate Interval Between Onset and Death Chours 8 months 8 months
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Be Completed by Dhusician/Madical Evamines	be completed by Physician medical Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 IPNo 9 Unknown Part II. Other significant conditions of the cause o	plications that caused one cause on each lir a. Due to (or as: b. Due to (or as: c. Due to (or as: d. Due to (or as: d. Due to (or as: d. Due to (or as: d. Due to (or as:	the death. Do ne. a consequence a consequence a consequence a consequence of pregnancy 2 Fetal death time of death	22. Name and Addres 136 East Bi not enter the mode of dying of): 3 □Ectopic pregnancy 5 □ Other (specify) □ In the underlying cause give	es of Facility Skaltimore g, such as cardiac of specific part I.	23a. Did tot 1 Yes 24a. Was an autoperform 1 Yes 24a. (Check only on	23d. 23d. 23d. 23d. 24d.	Date of delive Month sontribute to 1 prior to co death?	Approximate Interval Between Onset and Death Chows Smorths Smorths Pery Day Year the cause of death? bably 4 Dunknow opsy findings availab ompletion of cause of 20 No
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DHMH 17 Rev 1/2001

State Registrar

Itaron Zirke
31. Date filed (Month, Day, Year) MAR 0 7 2005

30. Name and address of person with Paron Zicker



completed cause of death (Item 23a) (Type, Print)

MD

2401 WBelvedere Avenue Baltimore Maryland

	1 - For State Registrar	State of Marylar	nd / Department of Certificate of		lental Hygiei	2000	"71. C
Physician /Medical	T = T=	Guarino			2. Date of Death	3. Time	of Death
Examiner Funeral Director	4a. Facility Name (II not institution, Penin Sula Legip 5. Social Security Number	give street and number) Out Nedical (1. Sex. 1 M 2 F	enter So	rs Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Death Wiconico 9. Birthplace (State Country)	
D	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Location		09-18-191	9 New York	
with the Mai 3a or 28a-f si 1 the notified	MD Somers 10e. Street and Number		incess Anne		10g.	Citizen of Whal Country?	· •
and 21215-0036 be filed within 72 hours after death with the Maryland ital hygiene. Ital hygiene. od other then "natural; or items 23s or 28s-f show event, the Medical Ever, her must be notified at event, the Medical Ever, her must be notified at Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of If Yes, specify C	f Hispanic Origin? (Spe uban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White	
1 21215-0 led within 72 ho ygiene. her then "natur. It, the Medical Completed	15. Decedent's (Specify only highest) Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	life. DO NOT use reti	e during most of working	ng 16b.	Kind of Business/Industry	
Maryland 21215-0036 d 2 should be filed within 72 hours att th and Mental hygiene. 27 is marked other then "natural", or traumatic event, the Medical Event To Be Completed by F	17. Father's Name (First, Middle, La	none ast)	Policeman	18. Mother's Name	(First, Middle, Maid	ty Police en Surname)	
Hear Hear Sherr	19a. Informant's Name/Relationshi, Edna A. Guarine 20a. Method of Disposition	o/Wife	11508 Dryden	Road, Pri	ncess Anne		
Baltimore, permit. Pages 1 ar Department of Hea Important: If item; any injury or other once.	1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify) St.	lace of Disposition (Name of emetery, crematory or other p Andrews Epis	1	200.	Location - City or Town, State	D
ilicate be executed fileate be executed physician and ss the burial-transit edical Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leaving to thin ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	mplications that caused the death live one cate on each line. a. A CUTE N Due to (or as a consequence of the consequence of t	11673 Som 1. Do not enter the mode of d 1. TRA CERE Lence of):	erset Ave., ying, such as cardiac or	Princess respiratory arrest, BLEED	Anne, MD 2185 Approxim Interval Onset and Z DA	iate letween d Death
the death cert by the attendin ached for use hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnat 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3 Ectopic pregnan eath 5 Other (specify)			23d. Date of delivery Month Day	Year
he law requires that the he law requires that the has been signed by the ige 2 should be detache mpleted by Phys	Part II. Other significant conditions HYPERTEN	ISION				use contribute to the cause of 2 Ano 3 Probably 4	
vital neco ician: The law of certificate has be rector, page 2 sh		TIVE HEAR	RT FAILU	RE	24a. Was an autopsy performed?	24b. Were autopsy finding prior to completion of death? 1 □ Yes 2 □ No	s available cause of
	25. Was case referred to medical examiner?	Hospital:		26. Place of Death			
_ > sp 2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury We	ury at 28 ork?	e 5 Residence 3d. Describe how inju	6 ☐Other (Specify) ury occurred	
Attender death by the ifficat	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be see stains at his	me, farm, street, factory office	Yes 2 □ No 28	3f. Location (Street a City or Town, Stat	ind Number or Rural Route Nur (e)	mber,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 Certifying I (Check only one)	Physician: To the best of my know aminer: On the basis of examinati and manner stated.	vledge, death occurred at the too and/or investigation, in my	ime, date and place, an opinion, death occurred	d due to the cause(s d at the time, date an	s) and manner as stated. Indicate, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier	Ta el		se number 5 4 6 9 6 5	29d. Da 2 FEB	RUARY 13, 2	005
	30. Name and address of person wh	o completed cause of death (Item M.D. PENINS u					
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	JIT OF THE STATE O				

		•	For State Registrar	State	of Maryland		artment of l				iene g. No.20 (05 07493
			1. Decedent's Name (First, Mic	idle, Last)					2	. Date of Death Month	1	3. Time of Death
	Physici /Medi		Rebecca Ger	trude Har	per				I	ebruar		005 11:49 P M
7	Examir		4a. Facility Name (If not institut	ion, give street and n	umber)		4b. City, Town,	or Location	of Death		4c. County of	Death
			Washington			a to Joseph at a . 1	Ta	koma		Date of Birth		ntgomery B. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. las	Yrs.	Months Days		Min.	(Month, Day,	Year)	Country)
			577-20-7928 Usual Residence of Decedent		04				1 1	eb. 15	, 1921 3	South Carolina
	death with the Maryland me 23a or 28a-f show findst be notified at		10a. State 10b. Coun	nty	10c. City, 7	Town or Lo	cation					10d. Inside City Limits
	a Ma	Director		ne Arundel				0dent	on			1 □XYes 2 □ No
	ith th	Dire	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wh	at Country?
	a 23a	ral	2247 Commis			10.1	Was Daniel of	21113		h. Van a. Na		ted States American Indian,
	ter de Itam	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ M.	Armed F	cedent Ever in U.S. Forces? 2)(X) No	13.	Was Decedent of f Yes, specify Cul	oan, Mexicar	n, Puerto Rio	an, etc.)		White, etc.
036	urs af	by	3√2 Widowed 4 □ Divorc	If Vac G	ive		1 ☐ Yes 21 No	Specify:	•		Specify:	Black
21215-0036	72 hours after natural', or Ita	Completed	15. Deced	ent's Education hest grade completed		16a. Dece	dent's Usual Occu	pation	st of working	1	6b. Kind of Busi	ness/Industry
21	ithin ithin	npie	Elementary/Secondary (0-12		(1-4or 5+)		DO NOT use retire		-1 org			
	led w lygier har th		12th	(2. (2.4)			_Laundry			Times Adjustation A.	Pri	Lvate
and	ibe fi	Be	17. Father's Name (First, Middle		11			18. 19101116	er s rvanie (r		Lee Mit	
Maryland	2 should be filed within 72 hours and Mental Hyglene. Is marked other than "netural", aumatic event, the Mydlon Fre	٦ و	19a. Informant's Name/Relatio	rancis Wa.		19b. Mailir	ng Address (Stree	t and Numbe	er or Rural F			
Ma	nd 2 s lith ar 27 ls r trau		Julie L. Haye				7 Commis					, i
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 Is marked other than "naturat", or iteme 23s or 28s-1 show other traumatic event, The Medical Erairia or trivial the notified at		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other pla		Date			ty or Town, State
e E	Pages nent of I nnt: If Its ury or o		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other		n State	-	emorial	. 1	2/23/2	2005	Lando	over, MD
Baltimore	permit. Pages Department of Important: If It any injury or once.		21. Signature of F@neral Service	ce Licensee	A		. Name and Addr					
<u>m</u>	8 2 E 2		John	. Slew	and III		4001	Benni	ng kd.	, N.E.	Wash.,	DC 20019
8			23a. Part . Enter the disease, shock, or heart failure. L	or complications that ist only one cause on	caused the death.	Do not ent	er the mode of dy	ing, such as	cardiac or r	espiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a	Cand	(1)	V0.04	the				Criset and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a consequer	nce of):	(- / /	/				
		- G	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consequer	nce of):		-				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1								
o,	be executed ician and burial-transit		resulting in death) Last	Due to	o (or as a consequer	nce of):						
8760	nys he	dicai		d							<u> </u>	
9		Med	IF FEMALE:						-			
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregnancy birth 2 Tetal de	eath 3	Ectopic pregnanc	у			23d. Date of Month	,
Ö	that the death cer ed by the attendin detached for use	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk	nant at time of deat nown	n sc	Other (specify) _		-			
٦.	The law requires that the death certific Ite has been signed by the attending p rage 2 should be detached for use as		Part II. Dther significant cond	itions contributing to	death but not resulting	ng in the u	nderlying cause g	ven in Part I	I.	23e. Did tob	acco use contribi	ute to the cause of death?
Records,	quires tha n signed I uld be det	ed by	ILANK	ini are						1 🗆 Ye	s 2 □ No 3	☐ Probably 4 ☐Unknown
00	aw requir s been si 2 should	Completed								24a. Was an		re autopsy findings available or to completion of cause of
R	The faw ite has bage 2 s	mo								autopsy perform 1 Yes 2	ed? dea	ath?] Yes 2 □ No
Vital		Be C	25. Was case referred to medie examiner?	cal				26. Place	e of Death (C	Check only one		
of V	S D	To	1 Yes 2 No	Hospital:		VOutpatien	t 3□ DOA Ot	her: 4 🗆 Nu	ursing Home	5 🗌 Resider	nce 6 Other	(Specify)
	Viter t		27. Manner of Death 1 Natural 5 ☐ Pend	ung	e of Injury nth, Day Year)	3b. Time of Injury	Wo	ork?		d. Describe how	w injury occurred	
sio	Attending in death: actor: After by the fune	cati	3 ☐ Suicide 6 ☐ Coul		be of Injury - At home	form etc		Yes 2		Location (Str	eet and Number	or Rural Route Number,
Division	I or Attend after death Diractor: / d in by the f	Certification:	4 Homicide dete	mined 200. Flat	ding, etc. (Specify)	5, Idi(III, SII	eet, factory, office		201	City or Town,		or riura, rioute riumber,
	Hospital		29a. Certifier 1 Certifi	ying Physicien: To th	ne best of my knowle	edge, death	occurred at the t	me, date an	nd place, and	due to the car	use(s) and mann	er as stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	Medical	(Check only 2 Medic one)	al Examiner: On the and ma	basis of examination nner stated.	and/or in	estigation, in my	opinion, dea	ath occurred	at the time, da	te and place, and	d due to the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certi	fier	_			se number				Month, Day, Year)
			Maria	lall	-Ph.D.	1.0	H3	6078	P		2-17-	-05
R	(2)		30. Name and address of pers	on who completed car	use of death (Item 2		Print)		. 0			20912
			STEVEN Full	or 760	Registrar's Signature	1 4	1E., ()	4 Com	4 1 9	16 m	1) (09/2
	Sta Registr		FEB 2.2	2005	w &	hon	R'					

			1 - For State Registrar	State of N	Maryland	-	artmen rtificate				•	giene Reg. Nor	005	5 (07494
	Dhysisi	-	Decedent's Name (First, Middle,	Last)		-					2. Date of De Month	ath Day	Ye	ear	3. Time of Death
	Physici /Medi		Homer Vaughan	Her	vey, S	r.					Februar				10:40P м
1	Examir		4a. Facility Name (If not institution,	give street and number	er)		4b. City,	Town, or	Location of	of Death		4c.	County of E	Death	
			5103 Westport I				Chev						ontgor		
	Funeral		,	6. Sex 7. /	Age (In yrs. Ia CO	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)	036	Country	
	Director		451-50-8534	124101 2231	68	TIS.					Septemb	<u>ser27</u>	,	Texa	S
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							100	d. Inside City Limits
	danyi f sho	ō	Md Montg	omery	CI	nevy (haca								1⊠Yes 2 No
	28a-	ect	10e. Street and Number	Olive Ly	01	ievy (10f. Zip	Code				10a. Citiz	zen of Wha	t Countr	v?
	with	ā					101. 2.1		815			-			, -
	eath	Funeral Director	5103 Westport R	12. Was Deceder	nt Ever in U.S	_ 13.	Was Deced			igin? (Spe	ecify Yes or No		U.S.A		n Indian,
	ter d	- L	1 Never Married 25 Marrie	Armed Force	s?		If Yes, spec	ify Cuba	n, Mexicar	i, Puèrto	ecify Yes or No Rican, etc.)			White, etc	
036	urs a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:		1 ☐ Yes 2	2⊠ No	Specify:				Specify: W	hite	:
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examinat must be multied at	Completed	15. Decedent'	s Education		16a. Dece	dent's Usua kind of wor	l Occupa	ation	t of work	ina	16b. Kir	nd of Busine	ess/Indu	stry
215	hin 7	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	or 5+)	life.	DO NOT us	e retired)	t of work	ing				
21	er th	5		5+		Sen	lor Of	fic					E.M.A	L	
pu	al Hy d oth	Be (17. Father's Name (First, Middle, L	ast)					18. Mothe	er's Name	(First, Middle,	, Maiden .	Sumame)		
<u>la</u>	Ment Ment arkec	၉	Charles E. Herv	ey					Amb	o1yn	Vaugh	an			
Maryland	2 shc and is m		19a. Informant's Name/Relationsh	ip (Type, Print)			-				al Route Numbe			-	
2	and ealth n 27		Nancy M. Hervey	<u>/ Wife</u>					Road		evy Cha				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or flems 23a or 28a-f show may injury or other traumatic evant, the Madical Expring must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Sta	te cer	metery, crei	sition (Nam matory or ot	her place			Date		cation - City		
Ĕ	Pag ment ant: ury c		* 4 □Donation 5 □ Other (Sp		Mt	. Oli	vet C	emet	ery F		23,2005				D.C.
at	ppart		21. Signature of Funeral Service L	icenses //			2. Name and				DeVol F				or organization and have
_	207 2 2		hier X	XIII		22	22 Wi	SCOL	sin A	Ave.	, N.W.W	ashi	ngton	,D.C	.20007
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caus only one cause on each	ed the death.	Do not ent	er the mode	of dying	g, such as	cardiac o	or respiratory a	rrest,		lr.	pproximate nterval Between
	Physician		Immediate Cause (Final disease or condition	Motos	static	Pros	tate	Can	cer						Inset and Death Year
1	/Medical		resulting in death)		as a conseque			- UMA	AMMA.						
н	Examiner		Sequentially list conditions.	b											
	ъ =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseque	ence of):									
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	am	Cause (Disease or injury that initiated events resulting in death) Last	c											
30,	e executados		rosuling in south, sust	Due to (or a	as a conseque	ence or):									
8760,	ate b hysic the b	lica		d	.										
9	leath certifica attending ph I for use as th	Physician/Medical	IF FEMALE:	00- W											
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal o	death 3	Ectopic pre					2	3d. Date of Month	,	ay Year
0	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9□ Unknown	at time of dea	ath 5∟	Other (spe	ecity)							
Р.	that the de ed by the detached		Part II. Other significant condition	ns contributing to death	hut not result	ting in the u	nderlying ca	ause nive	n in Part I		23e. Did to	obacco us	se contribut	te to the	cause of death?
18,	ires ti signe	by	Tarrii. Other significant contains	To contributing to abatt			ndonying oc	1400 g/*0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•		Yes 2[2	_		ly 4 □Unknown
Records,	w require been si should I	Completed													
ec	law last	npl			-						24a. Was autop		24b. Were prior deatl	to comp	y findings available letion of cause of
H	The Cate ha	Cor									1 ☐ Yes			Yes 2	□No
Vital	Physician: The far this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	11				01		of Death	(Check only o	ne)			
of	Physic this c	은	1 ☐ Yes 2 🔀 No		itient 2 E				4 140		me 51X Resid			Specify)	
Ü		Certification;	27. Manner of Death 1 XNatural 5 ☐ Pending		Day Year)	28b. Time o Injury		3c. Injury Work			28d. Describe I	now injury	occurred		
Division	tan leat tor: the	cat	2 Accident investigation inves	01 10			М		/es 2 □		004	C44	1 4 (- 0 1 0	2- 4- 46
Ξ	for Attanater deatl	Ħ	4 Homicide determin	ned 200. Flace of I	etc. (Specify)	ie, rami, str	eet, factory,	office			28f. Location (S City or Tox		r rumber o	r Hurai H	soute rvumper,
	ours a		CO- C-different AFT Co-different	Dhorida Tattab		1-d-a dask	<u> </u>		- 4010.00	d place					
	Hos 24 ho Fund Fund tely f	edical		Physician: To the best	of xaminatio										
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Med	29b. Signature and title of certifier	and manger	gratou.		29c.	License	number			29d. Date	signed (M	fonth, Da	y, Year)
	₩ ¥ 5 8		Y	41/											
	U			100-	5 d = - 15 '''	20-1/7		D003	3293	3		Febru	ary 1	17,	2005
	•		30. Name and address of person					#11	300 0	ho	Chaca	ма	2001 =	_600	18
	OL.		Frederick P. Smi 31. Date filed (Month, Day, Year)					1/1.	700 C	пелу	onase,	riu .	40013	-090	
	Sta Registi		FEB 18	2005	strar's Signatu	600	de								

				For Amend Item#2, per PHY, Wary and 12, per Fer Registrar Certific	ent of Healtl	h and Me		ene g. No.20 ()5	07495			
				Decedent's Name (First, Middle, Last)			2. Date of Death	2/15/0		3. Time of Death			
		Physici /Medic		Monroe Thomas Hyde		.4	ebruar		005	4:25P ^M			
		Examin		, and the state of	City, Town, or Locati			4c. County of Death					
				•	Mestminste		Carroll						
\		Funeral Director			nths Days Hou	irs Min.	B. Date of Birth (Month, Day, June 11.	Year)	Coun	lace (State or Foreign try) y l and			
17				Usual Residence of Decedent			June	, . <u></u>					
0		anylan show	Ŀ	10a. State 10b. County 10c. City, Town or Location					1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No			
<i>></i>	•	he Ma	Director	MD Carroll Westminste	of, Zip Code		10	g. Citizen of W	hat Coun				
1		with the or 3	D	219 John Hyde Rd.	21158		10	U.S.A.	nat Coun	uyı			
S		death ms 23	Funeral I	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was D	Decedent of Hispanic , specify Cuban, Mex	Origin? (Spec	ify Yes or No-	14. Race		an Indian,			
(A	ထ္	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23e or 28e-f show ent, It e Medical Evaciliser must be rediffed at	Fur	1 □ Never Married 2 Married 1 □ X es 2 □ No	specify Cuban, Mex es 2 No Spec		Carr, etc.)	Specify:	, White,				
THOMA	21215-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Usual Occupation			6b. Kind of Bus		ite			
E	5	in 72 in mat	Completed	(Specify only highest grade completed) (Give kind of life, DO No	of work done during r OT use retired)	most of working	7 '	db. Killd of Bus	111622/1110	lustry			
-	212	d with giene. rr ther	mo	Elementary/Secondary (0-12) College (1-4or 5+) bookke	eper .		9	stone q	uarr	y/trucking			
111	nd	al Hyg	BeC	17. Father's Name (First, Middle, Last)	18. M		First, Middle, M)				
20	yla	ould to Ment Marked	To	John S. Hyde			C. Lipp	•					
2	Mar	permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene, Importent: if Item 27 is marked other then "n any injury or other treumatic event, If # Me 1i		, , , ,	dress (Street and Nu ittlestown								
2	ē,			20a Method of Disposition 20b. Place of Disposition	(Name of	Da		0c. Location - 0					
MONKUE	Б			1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Winters Cen		2/18/2	2005	New Win	ndso	r, MD			
2	Baltimore, Maryland	partm porter y inju			me and Address of Fa	acility Hat	rtzler F	- uneral	Home	e			
	<u> </u>	20 5 5			Church St				1776				
		Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
				Immediate Cause (Final disease or condition resulting in death) a. CWGESTIVE HEART FAILURE									
	L		Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	-								
_		cuted od ransit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
	0,	ate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):									
	8760,	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transi	dicai	d									
	9	certific ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date	of delive	erv			
	Вох	death attended for u	Physician/Me	in the past 12 months? 4 Pregnant at time of death 5 Other	pic pregnancy er (specify)			Mon		Day Year			
	P.0.	t the c by the achec	hysi	9 Unknown 9 Unknown									
		w requires that s been signed b should be deta	by P	Part II. Dther significant conditions contributing to death but not resulting in the underly	/ing cause given in P	Part I.				ne cause of death?			
	ord	equiri	ted	CORONALY ANIEW DISEASE			1 Ves			ably 4 Honknown			
	ec	law I	Completed				24a. Was an autopsy perform	pr	ere auto ior to cor eath?	psy findings available mpletion of cause of			
	E F	icien: The lav certificate has rector, page 2					1 ☐ Yes 2	1 No 1	Yes	2□ No			
	Vit	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3[Other		(Check only one		r (Snacih				
	Division of Vital Records,	g Phys er this eral dii	—										
	ion	anding fath. or: After or funer	atio	2 Accident investigation M					_				
	Vis	ter de irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28	3f. Location (Street, City or Town,	eet and Numbe State)	r or Rura	I Route Number,			
	Ω	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occi	urad at the time, dot	to and place, as	ad due to the ear	use(s) and man	200 00 00	Pated			
		24 hos Fundately f	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.	jation, in my opinion,	, death occurred	d at the time, da	te and place, a	nd due to	the cause(s)			
_		ro the vithin ro the comple	Me	29b. Signature and file of certifier	29c. License numb	ber	29	d. Date/signed	(Month,	Day, Year)			
		WIL		pular forbelle	40058	8598	2	2/16/0	15				
		MJO		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		-1 0-	-	K	ES	TERSAUN,			
				DL - TK/NH R - TKHKEL 113 LLS 31. Date filed (Month, Day, Year) 32. Regener's Signature	THINSTE,	Z XI)	SUIR	101 1	10	21136			
		Sta Regist		FEB 1 8 2005	sile								

			For State Registrer	State of M	aryland	d / Depa <i>Cer</i>	rtment tificate	of H	ealth a Death			Reg. No.	201	05		497				
	Physicia	an	Month Day Year												3. Time of					
>	/Medic	al	Macil Pana Pinnoriche Penthary IS. 7005 3											3:0	1 P M					
	Examin	er	Shady Grove Advent	Rocky			Dealli			ntgo										
	Funeral		5. Social Security Number 6. Se	x 7. A		ast birthday)	If Under 1		If Under 2	24 Hrs.	8. Date of Bir (Month, Da	th			lace (State o	or Foreign				
	Director		344-01-1594]M 2∰F	8.	5 Yrs.	MOTUTS	Days	Hours		Dec. 9	19	19		nois					
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10	0d. Inside C	ity Limits				
36	Maryl f sho	ō	Maryland Montgomer	•v	Monts	gomery	Villa	age							1 🗌 Yes	2 X No				
	r 28a	rec	10e. Street and Number		1	<u> </u>	10f. Zip C					10g. Citiz	en of Wi	hat Coun	try?					
	th witt	aiD	19017 Mills Choice	Road			2088	86				USA								
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 ☐ Married 3 □ Widowed 4 □ Divorced				Vas Decede Yes, specif		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	Rican, etc.)			. Race - American Indian, Black, White, etc. ^{pecify:} White						
9	2 hou	ted !	15. Decedent's Edu	cation		16a. Deced	ent's Usuai	Occupa	ition	4				iness/Ind						
21215-0036	within 73 ene. then "na	ple	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or	life. I			e kind of work done during most of worki DO NOT use retired)												
21	e filed within all Hygiene. other then 'vent, It's Me	Completed	11	11 Homemaker								Own Home								
und	Aental H rked oth tic even	Be	17. Father's Name (First, Middle, Last) Henry Goetting								(First, Middle alger	liddle, Maiden Surname)								
7	2 should be and Mental is marked isumatic ev	ဥ	19a. Informant's Name/Relationship (T)	vna Print)		19b Mailin	a Address /				Route Numb	er. City or	Town S	state. Zin	Code) 20	0886				
Maryland	od 2 s lith an 27 is r trau		Marilynn Schreibst		hter	19017									20	J000				
re,	s 1 and 3 f Health Item 27 other tr	H	20a. Method of Disposition		20b. Pl	ace of Dispos	sition (Name	e of	1 7	Febru	-		ocation - City or Town, State							
Ë	Page nent o int: If	li	1 ☐ Burial 2)	Arunde				21, 2	005	0den	ton,	Mar	y1and					
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot once.		21. Signature of Funer Service Licens	alte	MO1						Servi					1029				
			23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD21 Approximate Interval Behavior and the complex of the deeth in the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											te tween						
	Physician		Immediate Cause (Final disease or condition	Due to (or as a consequence of): Onset and D MONT																
	/Medical Examiner		resulting in death)																	
	Ladiiiiio	<u></u>	Sequentially list conditions,	b. Due to (or as	s a consequ	uence of):					_									
Т	uted I Insit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury																	
Ć,	exection and ial-tra		that initiated events resulting in death) Last	Due to (or as	s a consequ	ience of):														
8760,	cate be executed physician and the burial-transit	edicai		d																
). Box 68	death certifi e attending ed for use as	/sician/Med	ysician/Med	ysician/Med	Physician/Med	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pred Other (spec					2	3d. Date Mont	of delive		Year
P.0	res that the de signed by the a be detached to		Part II. Other significant conditions co	ntributing to death	but not resu	ulting in the ur	nderlying cau	use give	n in Part I.		23e. Did 1	obacco us	se contrib	oute to th	e cause of o	death?				
rds	quires n sign ald be	d by							18	Yes 2	No 3	B 🗆 Prob	ably 4 □I	Unknown						
Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	ompleted						-			24a. Was auto perfo 1 \(\sum \text{Yes}\)	psy ormed?	pr. de	ere autorior to coreath?	psy findings npletion of c	available cause of				
/ita	icien: The certificate ector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only one)																
of \	Physicien: r this certific ral director,	2	1 Tes 2 K	Hospital: 1 KInpat		ER/Outpatien	Tentan and the second	and the state of	4 🗀 140	11	e 5 Resi				/)					
on c		lon	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?							28d. Describe how injury occurred									
Division	aatl or:	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Ir							28f. Location (Street and Number or Rural Route Number,									
<u>S</u>	al or A after I Dire	Certification;	4 Homicide determined building, etc. (Specify)								City or Town, State)									
	To the Hospitel or Att. within 24 hours after de To the Funerel Direct completely filled in by the	edicai (5)							
)	To the within 2 To the comple	W	29b. Signature and title of certifier Chike References	ynel			MA	RYL			1412	FEB	RUA	RY	Day, Year)	005-				
62	•			HILIP D	RIVE	, #=	Print) DX	OL1	NEY	MA	JAGO. RYLAN	PAL,	m. 1). 32.						
	Sta Registi	-	31. Date filed (Month, Day, Year)	005 32. Regis	trar's Signal	ture	sails)	,												

		State of Maryland / D	epartment of Health and M Certificate of Death		000 0/490							
Physic /Med Exam	lical	Decedent's Name (First, Middle, Last) Clifford A. Harris, Sr. 4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month Day Feb 10 4c.	County of Deeth							
Funera Directo		Howard County General Hospital 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birth 4 Y Usuel Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 19, 1	940 9. Birthplece (State or Foreign Country) Wash., DC							
ith the Maryland or 28a-f ahow	Olrector	10a. State 10b. County 10c. City, Town Maryland Howard 10e. Street and Number	Columbia 10f. Zip Code		10d. Inside City Limits 1 🛣 Yes 2 □ No zen of What Country?							
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23e or 28a-f ahow other traumatic avent, the Medical Evant, not must be notified at	by Funeral Director	10850 Green Mountain Circle #11 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:	.5 21044 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	1	United States 14. Race - American Indian, Black, White etc. African Specify: American							
ed within 72 horygiene. ser than "natur. t, the Medical E	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) 12th	Decedent's Usual Occupation Give kind of work done during most of workin life. DO NOT use retired) Civil Engineer (D	OT)	Government							
2 should and Men is marke	To Be			Dorothy Belton A Route Number, City or Town, State, Zip Code)								
Page nent o		20a. Method of Disposition 20b. Place of cemetery	Disposition (Name of crematory or other place)	200. Lo	rentwood, MD							
Dermit. Departr Imports any inje		21. Signature of Fuheral Service Licensee 22. Name and Address of Facility Stewart Funeral Hom 4001 Benning Rd., N.E. Wash., DC 20 23a. Parl 1. Filter the disease, or complications that caus the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line.										
Physiciar /Medica Examine	I I	Immediate clase (Final disease or contition resulting in death) a. Mocardial Due to (or as a consequence of the condition o		ar Disea	Onset and Death 7-14 days							
ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):										
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v requires that been signed b	þ	Part II. Other significant conditions contributing to death but not resulting in		ise contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☐ ☐ Miknown								
iclan: The law icertificate has breector, page 2 st	e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed? 1 es 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Pes 2 No							
this at du	Certification: To B	exarp/fier? 1 Yes 2 No Hospital: 1 Inpatient 2 PROutpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Spe 27. Many of Death 1. Whatural 5 Pending Investigation 1 North, Day Year) 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office 28f. Location (Street and Number or Riverset)										
To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical Certi	4 Homicide building, etc. (Specify) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To the within 7 To the comple	Mec	and manner stated. Tob. Signature any title of certifies WWW	29c. License number 12 D31473		te signed (Month, Day, Year)							
((0) S	tate	30. Name and address person who complete cause of death (Item 23a) (TPATEY CEA. TOYE, MD 4565 31. Date filed (Month, Day, Year) 7. Registrar's Signature	Hamlock Cone Way	1. Ellicutt	City, MD 21042							

		1 - For State Registrar		State of	Marylar		artmen				l ental	-	ene ()	05	07499			
		Decedent's Name (First, Middle, Last) 2. Date												Day Year 3. Time of Death				
Physic /Medi		GERARDO JER	FEB						16,	2005	9:29 P M							
Exami		4a. Fecility Name (If not in	stitution, give	street and numb	oer)		4b. City,	Town, or	Location of	of Death			4c. Cou	nty of Death				
	581	8013 BRIDGE						STER	1/11-1-	0.11				EN ANI				
Funeral Director		5. Social Security Number 579–30–2754 Usual Residence of December 1	1]	X 2□F 7.	76	last birthday, Yrs.	Months	Days	If Under Hours	Min.	8. Date of (Month) JUNE	Birth Day, 1	1928	Cou	place (State or Foreign Intry) DISTRICT OLUMBIA			
land ow			County		10c. Cit	ty, Town or L	ocation								10d. Inside City Limits			
Mary -f sh	tor	MD QU	EEN AN	NE'S	СН	ESTER									1 □Yes 2X No			
r 289	Director	10e. Street and Number					10f. Zip Code						g. Citizen o	of What Cou	intry?			
th wit	ai D	8013 BRIDGEPOINTE DRIVE						21619										
r dea	Funerai	11. Marital Status		12. Was Decede	es?	.S. 13.	Was Dece	dent of Hi	spanic Ori	igin? (Spe	ecify Yes o	r No-		ace - Ameri lack, White,				
ite; INIAI ylation Z IZ IS-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Evantinat must be notified at	by Fu	1 Never Married 2		If Yes, Give	□No 19	51-	1 ☐ Yes		Specify:		,	,		ify: WHI				
turat Fire		3 Widowed 4 Di	ecedent's Edi	Year or Date	s: 19	160 Dece	edent's Usus	al Oanua	tion									
in 72	Completed	(Specify only	highest grad	de completed)		(Give	kind of wo	rk done a	luring mos	t of worki	ing	10	ob. Kina of	Business/In	idustry			
the lease of the l	mo	Elementary/Secondary ((0-12)	College (1-4	or 5+)		BINDE						PRIN	TTNG				
e filed Hyg other	Be C	17. Father's Name (First, I	Middle, Last)						18. Mothe	er's Name	(First, Mi	ddie, Ma						
Id be Aenta Aenta rked tic ex	To B	FELICE IACA	NGELO						LUCIA	A CI	CCONE							
2 should and Men Is marke		19a. Informant's Name/Re	elationship (T	ype, Print)		19b. Maili	ing Address	(Street a	nd Numbe	er or Rura	I Route No	umber, (City or Tou	n, State, Zip	Code)			
and and and and and and and and and and		FERNANDA IA	CANGEL	O/WIFE		8013	BRID	GEP01	NTE I	DRIV	E, CH	ESTE	ER, M	216	519			
of He of He		20a. Method of Disposition 1 X Burial 2 Cren		Removal from Sta	20b. F	Place of Disponentery, cre I'E OF	osition (Nar matory or o	ne of ther place	9)		Date	20	c. Location	n - City or To	own, State			
mit. Pages partment of portant: If it y injury or o		`4 □Donation 5 □O			CE	METERY	HEAVE	N	0)2/19	/2005	5	SILVE	R SPR	ING, MD			
parmit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 2005.		21. Signature of Funeral S	Service Licens	le lenke	en	F. 1	2. Name an ELLOW: 06 SH	Addres	s of Facilit ELFEN CK RO	BEIN DAD.	& NE	WNAI ER	1 FUN	ERAL I 21619	HOME, P.A.			
		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												Approximate Interval Between				
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that the death ed by the atter	ysi	1 □ Yes 2 □ No 9 □ Unknown		9☐ Unknow								-						
uires that signed b	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. C	oid toba	tobacco use contribute to the cause of death?						
requires een sign	q p										1	☐ Yes	2 🗆 No	3 🗀 Prob	pably 4 Honknown			
law requir	Completed										24a. V	√as an	as an 24b. Were autopsy findings available					
The late has age 2	E										P	utopsy	d?	prior to co	mpletion of cause of			
Vical new ician: The law certificate has rector, page 2	0	25. Was case referred to 1	nedical						26. Place	of Death	(Check of	es 20	I NO	1 🗆 Yes	2 NO			
ysici ysici is ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No		Hospital:	atient 2	ER/Outpatier	nt 3 DC	A Othe			ome 5 ≃ Hesidence 6 □Other (Specify)							
ng Phy rer this		27. Mann J of Death	Pending	28a. Date of I (Month,	njury Day Year)	28b. Time o Injury	f 2	8c. Injury Work		7	28d. Descr							
ending sath. or: After	atic	2 Accident	investigation		(Month, Day Year) Injury				es 2 🗆 N	No								
or Att ter de irect	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of building,	Injury - At ho	ome, farm, sti	reet, factory	, office		2	28f. Locatio City or	n (Stre	et and Nun State)	nber or Rura	l Route Number,			
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	Check only 2 M	ertifying Phy edical Exami	sician: To the be ner: On the basis	s of examina	wledge, deat tion and/or in	h occurred vestigation.	at the time in my op	e, date and inion, deat	d place, a	and due to ed at the ti	the caus	se(s) and r and place	nanner as st	tated. o the cause(s)			
thin 2 the mple	Med	one) 29b. Signature and title of		and manner	stated.			. License			-			ed (Month,				
E 2 4 8		11 6	11/1	2/m	-D			032										
		30. Name and address of	person who o	omoleted cause	of death /Ite-	23a) (Tune		VIC) > /					7-200				
1014		Daniel	- 1-	rijck /	71).	130	Luve P	Bint 1	Cd., #	407	, St	every	ville	mp	21666			
Sta Regist	ate rar	31. Date filed (Month, Day	EB 1	3 2005 Regi	istor's Signa	iture		W. 5			/							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 14, 2005 February 8:21 A Thelma M. Jackson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours 1□M 2\ F Days 1906 223-10-2864 98 July 6, Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show rel', or items 23a or 28a-f shov Examiner roust be nutified at 1XIYes 2 □ No Completed by Funeral Director D.C. N/A Washington 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20019 3808 Hayes Street, N.E. #3 United States Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. In the Mealth and Mental Hygiene. Int: If item 27 is marked othar then "neturel", or Items 236 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African American lf Yes, Give Year or Dates: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Peoples Drug Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Manning Ada Meggison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14424 Bakersfield Ct., Silver Spring, MD 20906 item 27 i Charles N. Jackson, II Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Department of H
Importent: If ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/17/05 Gate of Heaven Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licensee 7400 Georgia Ave. N.W., Washington, D.C. 20012 vanna 23a. Patti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician seels Bleed Gastra Intestinal disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical as the t IF FEMALE use a 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2. No 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 0 this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1_Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760 To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After within 7

Bewett Morion m) egistrar's Signature 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number 47682

29d. Date signed (Month, Day, Year) February 14, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2901 Olney-Sandy Spring Road, Olney, Maryland, 20832 Bennett Morrison

State Registrar 1 8 2005